

Exhibit G

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

*Standard Contract
Amendment*

For

Fee-For-Service Carriers

2018

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2018A
EFFECTIVE: January 1, 2018

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G. Street, NW, Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

FOR THE GOVERNMENT

William A. Breskin
Name of Person Authorized to
Execute Contract (Type or print)

Sylvia V. Pulley
Name of Contracting Officer (Type or print)

Senior Vice President, Government
Programs
Title

Contracting Officer
Health Insurance Group I
Title


Signature


Signature

12/20/17
Date Signed

12/26/2017
Date Signed

1. Section 1.9 Plan Performance—Fee-For-Service Contracts

Section 1.9 of the FEHB Fee-For-Service Standard Contract must be amended to reflect the updated Fraud, Waste, and Abuse (FWA) reporting requirements established in Carrier Letter 2017-13. The Carrier Letter established these requirements in Attachments 1 and 5 of the Carrier Letter to be utilized beginning with the 2018 contract year.

SECTION 1.9**PLAN PERFORMANCE—FEE-FOR-SERVICE CONTRACTS (JAN 2018)**

(a) Detection of Fraud, Waste, and Abuse (FWA). The Carrier shall conduct a program to assess its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively. The Carrier shall operate a system designed to detect and eliminate FWA internally by Carrier employees and Subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. In addition, FEHBP Carriers must demonstrate they have submitted written notification to OPM-OIG within 30 business days of identifying potential FWA issue impacting the FEHB Program regardless of dollar value. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its FWA program. The Carrier must submit annual reports to OPM by March 31 addressing the following:

- 1) Number of Allegations/Complaints Opened/Received;
- 2) Number of Allegations/Complaints where there is FEHBP Program Exposure;
- 3) Number of Cases Developed Through Proactive Fraud Prevention/Detection Software;
- 4) Number of Cases Referred to Local, State, or Federal Law Enforcement/Oversight Agencies;
- 5) Number of Case Notifications/Referrals Sent to OPM-OIG;
- 6) Number of Cases Resolved Administratively;
- 7) Dollars Identified as Loss;
- 8) Estimated Financial Losses;
- 9) Non-Recoverable Loss;
- 10) Dollars Recovered by SIU;
- 11) Vendor Recoveries;
- 12) Actual Savings;
- 13) Prevented Loss;
- 14) Number of Criminal Convictions;
- 15) Prepayment Review;
- 16) Fraudulent Schemes;
- 17) Fraudulent Geographic Areas;
- 18) FWA Program Costs;
- 19) Other Associated Costs of the FWA Program;
- 20) Return on Investment; and
- 21) Best Practices

The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare

Effectiveness Data and Information Set (HEDIS), measures developed by the Pharmacy Quality Alliance (PQA), and similar measures developed by accrediting organizations such as, but not limited to, the Association for Ambulatory Health Care (AAAHHC), the National Committee for Quality Assurance (NCQA), and URAC or endorsed by the National Quality Forum. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility and are allowable administrative expenses, subject to the administrative cost limitation.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

- (1) Report to OPM on its current patient safety initiatives;
- (2) Report to OPM on how it will strengthen its patient safety program for the future;
- (3) Assist OPM in providing its Members with consumer information and education regarding patient safety; and
- (4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined by OPM. The Carrier shall submit accreditation changes and updates to its OPM contract representative.

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Consumer Assessments of Healthcare Providers and Systems (CAHPS) to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period:

- (1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately and the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

- (2) *Claims Coding Accuracy* - the number of FEHB claims coded accurately divided by the total number of FEHB claims coded for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 98 percent of FEHB claims shall be coded accurately.

- (3) *Recovery of Erroneous Payments* - the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier takes an average of no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Coordination of Benefits (COB)* - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(5) *Claims Timeliness* - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD: The Carrier adjudicates 95 percent of claims within 30 working days.

(6) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier will issue ID cards resulting from an open season election within fifteen calendar days or by December 15, whichever is later.

(7) *Member Inquiries* - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage, for the given time period.

REQUIRED STANDARD: The Carrier responds to 90 percent of inquiries within 15 working days (including internet inquiries).

(8) *Written Inquiries Accuracy* - the number of FEHB written inquiries handled accurately divided by the total number of FEHB written inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB written inquiries shall be answered accurately.

(9) *Telephone Inquiries Accuracy* - the number of FEHB telephone inquiries handled accurately divided by the total number of FEHB telephone inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB telephone inquiries shall be answered accurately.

(10) *Internet Inquiries Accuracy* - the number of FEHB Internet inquiries handled accurately divided by the total number of FEHB Internet inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB Internet inquiries shall be answered accurately.

(11) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) *Call Answer Timeliness* - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 30 seconds elapse before the Carrier connects a member's telephone call to its service representative.

(ii) *Telephone Blockage Rate* - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: No more than 5 percent of callers receive a busy signal.

(iii) *Telephone Abandonment Rate* - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, Enrollees abandon the effort no more than 5 percent of the time.

(iv) *Initial Call Resolution* – the percentage of issues resolved during the initial call.

REQUIRED STANDARD: On average, caller's issues must be resolved during the initial call at least 80 percent of the time.

(12) *Responsiveness to FEHB Member Requests for Reconsideration*:

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide or authorize coverage of the service, or request additional information reasonably necessary to make a determination.

(g) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(h) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(i) FEHB Clearinghouse (CLER). The Carrier shall not have any CLER records with a 160 error code and a fail count of four or higher. A '160' error is when a Carrier reports an enrollment but no agency or Tribal Employer reports that enrollment.

(j) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph (j) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(k) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (j).

2. Section 5.14 Utilization of Small Business Concerns

Subsection (a), and (d) were amended in accordance to November 2016 FAR Clause FAR 52.219-8. The contractor may accept the written representation of the subcontractor size and socioeconomic status if certain requirements are met.

SECTION 5.14

UTILIZATION OF SMALL BUSINESS CONCERNS (NOV 2016) (FAR 52.219-8)

(a) Definitions. As used in this contract --

“HUBZone small business concern” means a small business concern, certified by the Small Business Administration, that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.

“Service-disabled veteran-owned small business concern”

(1) Means a small business concern—

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

“Small business concern” means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

“Small disadvantaged business concern”, consistent with 13 CFR 124.1002, means a small business concern under the size standard applicable to the acquisition, that--

(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—

(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and

(ii) Each individual claiming economic disadvantage has a net worth not exceeding \$750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition.

“Veteran-owned small business concern” means a small business concern—

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

“Women-owned small business concern” means a small business concern—

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small

business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(c) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(d)(1) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, a veteran-owned small business, service-disabled veteran-owned small business or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(2) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if—

(i) The subcontractor is registered in SAM; and

(ii) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(3) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(4) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(5) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the System for Award Management database or by contacting the SBA. Options for contacting the SBA include—

(i) HUBZone small business database search application web page at

http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or <http://www.sba.gov/hubzone>;

(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or

(iii) The SBA HUBZone Help Desk at hubzone@sba.gov.

3. Section 5.19 Equal Opportunity

Subsections (a) and (c)(5) were amended in accordance to the September 2016 FAR Clause 52.222-26. Definitions for "Compensation", "Compensation information" and "Essential job functions" are now included in the amended FAR clause. Language has been added to prohibit the Contractor from discharging or discriminating against an employee or applicant based on certain activities regarding disclosure of compensation.

SECTION 5.19

EQUAL OPPORTUNITY (SEP 2016) (FAR 52.222-26)

(a) Definition. As used in this clause

“Compensation” means any payments made to, or on behalf of, an employee or offered to an applicant as remuneration for employment, including but not limited to salary, wages, overtime pay, shift differentials, bonuses, commissions, vacation and holiday pay, allowances, insurance and other benefits, stock options and awards, profit sharing, and retirement.

“Compensation information” means the amount and type of compensation provided to employees or offered to applicants, including, but not limited to, the desire of the Contractor to attract and retain a particular employee for the value the employee is perceived to add to the Contractor’s profit or productivity; the availability of employees with like skills in the marketplace; market research about the worth of similar jobs in the relevant marketplace; job analysis, descriptions, and evaluations; salary and pay structures; salary surveys; labor union agreements; and Contractor decisions, statements and policies related to setting or altering employee compensation.

“Essential job functions” means the fundamental job duties of the employment position an individual holds. A job function may be considered essential if—

- (1) The access to compensation information is necessary in order to perform that function or another routinely assigned business task; or
- (2) The function or duties of the position include protecting and maintaining the privacy of employee personnel records, including compensation information.

“Gender identity” has the meaning given by the Department of Labor’s Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

“Sexual orientation” has the meaning given by the Department of Labor’s Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

“United States,” means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b)(1) If, during any 12-month period (including the 12 months preceding the award of this contract), the Contractor has been or is awarded nonexempt Federal contracts and/or subcontracts that have an aggregate value in excess of \$10,000, the Contractor shall comply with this clause, except for work performed outside the United States by employees who were not recruited within the United States. Upon request, the Contractor shall provide information necessary to determine the applicability of this clause.

(2) If the Contractor is a religious corporation, association, educational institution, or society, the requirements of this clause do not apply with respect to the employment of individuals of a particular religion to perform work connected with the carrying on of the Contractor’s activities (41 CFR 60-1.5).

(c)(1) The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. However, it shall not be a violation of this clause for the Contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation, in connection with employment opportunities on or near an Indian reservation, as permitted by 41 CFR 60-1.5.

(2) The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. This shall include, but not be limited to—

- (i) Employment;
- (ii) Upgrading;
- (iii) Demotion;
- (iv) Transfer;

- (v) Recruitment or recruitment advertising;
- (vi) Layoff or termination;
- (vii) Rates of pay or other forms of compensation; and
- (viii) Selection for training, including apprenticeship.

(3) The Contractor shall post in conspicuous places available to employees and applicants for employment the notices to be provided by the Contracting Officer that explain this clause.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(5) (i) The Contractor shall not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This prohibition against discrimination does not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with the Contractor's legal duty to furnish information.

(ii) The Contractor shall disseminate the prohibition on discrimination in paragraph (c)(5)(i) of this clause, using language prescribed by the Director of the Office of Federal Contract Compliance Programs (OFCCP), to employees and applicants by—

(A) Incorporation ~~into~~ existing employee manuals or handbooks; and

(B) Electronic posting or by posting a copy of the provision in conspicuous places available to employees and applicants for employment.

(6) The Contractor shall send, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, the notice to be provided by the Contracting Officer advising the labor union or workers' representative of the Contractor's commitments under this clause, and post copies of the notice in conspicuous places available to employees and applicants for employment.

(7) The Contractor shall comply with Executive Order 11246, as amended, and the rules, regulations, and orders of the Secretary of Labor.

(8) The Contractor shall furnish to the contracting agency all information required by Executive Order 11246, as amended, and by the rules, regulations, and orders of the Secretary of Labor. The Contractor shall also file Standard Form 100 (EEO-1), or any successor form, as prescribed in 41 CFR Part 60-1. Unless the Contractor has filed within the 12 months preceding the date of contract award, the Contractor shall, within 30 days after contract award, apply to either the regional Office of Federal Contract Compliance Programs (OFCCP) or the local office of the Equal Employment Opportunity Commission for the necessary forms.

(9) The Contractor shall permit access to its premises, during normal business hours, by the contracting agency or the OFCCP for the purpose of conducting on-site compliance evaluations and complaint investigations. The Contractor shall permit the Government to inspect and copy any books, accounts, records (including computerized records), and other material that may be relevant to the matter under investigation and pertinent to compliance with Executive Order 11246, as amended, and rules and regulations that implement the Executive Order.

(10) If the OFCCP determines that the Contractor is not in compliance with this clause or any rule, regulation, or order of the Secretary of Labor, this contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts, under the procedures authorized in Executive Order 11246, as amended. In addition, sanctions may be imposed and remedies invoked against the Contractor as provided in Executive Order 11246, as amended; in the rules, regulations, and orders of the Secretary of Labor; or as otherwise provided by law.

(11) The Contractor shall include the terms and conditions of this clause in every subcontract or purchase order that is not exempted by the rules, regulations, or orders of the Secretary of Labor issued under Executive Order 11246, as amended, so that these terms and conditions will be binding upon each subcontractor or vendor.

(12) The Contractor shall take such action with respect to any subcontract or purchase order as the Contracting Officer may direct as a means of enforcing these terms and conditions, including sanctions for noncompliance, provided, that if the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of any direction, the Contractor may request the United States to enter into the litigation to protect the interests of the United States.

(d) Notwithstanding any other clause in this contract, disputes relative to this clause will be governed by the procedures in 41 CFR part 60-1.

4. Section 5.60 Subcontracts for Commercial Items

Subsection (c)(1) requires prohibitions on whistleblowing to flow down to subcontracts.

Additionally, the ~~Fair Pay~~ and Safe Workspaces rule was required by Congress to have no force or effect.

SECTION 5.60

SUBCONTRACTS FOR COMMERCIAL ITEMS (NOV 2017) (FAR 52.244-6)

(a) Definitions. As used in this clause —

“Commercial item” and “commercially available off-the-shelf item” have the meanings contained in Federal Acquisition Regulation 2.101, Definitions.

“Subcontract” includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Oct 2015) (41 U.S.C. 3509), if the subcontract exceeds \$5.5 million and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

- (iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).
- (iv) 52.204-21, Basic Safeguarding of Covered Contractor Information Systems (June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204-21.
- (v) 52.219-8, Utilization of Small Business Concerns (Nov 2014) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds \$700,000 (\$1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.
- (vi) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)
- (vii) 52.222-26, Equal Opportunity (Apr 2015) (E.O. 11246).
- (viii) 52.222-35, Equal Opportunity for Veterans (Oct 2015) (38 U.S.C. 4212(a)).
- (ix) 52.222-36, Equal Opportunity for Workers with Disabilities (Jul 2014) (29 U.S.C. 793).
- (x) 52.222-37, Employment Reports on Veterans (Feb 2016) (38 U.S.C. 4212).
- (xi) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.
- (xii)(A) 52.222-50, Combating Trafficking in Persons (Mar 2015) (22 U.S.C. chapter 78 and E.O. 13627).
- (B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).
- (xiii) 52.222-55, Minimum Wages under Executive Order 13658 (Dec 2015), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.
- (xiv) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.
- (xv)(A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).
- (B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).
- (xvi) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).
- (xvii) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.
- (xviii) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).
- (2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.
- (d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

5. Section 5.63 System for Award Management

Subsections (a), (b), and (c) were amended in accordance to the October 2016 FAR Clause 52.204-7. The System for Awards Management has revised the numbers used for contractors' unique entity identifier.

SECTION 5.63SYSTEM FOR AWARD MANAGEMENT (OCT 2016) (FAR 52.204-7)

(a) Definitions. As used in this provision—

“Electronic Funds Transfer (EFT) indicator” means a four-character suffix to the unique entity identifier. The suffix is assigned at the discretion of the commercial, nonprofit, or Government entity to establish additional System for Award Management records for identifying alternative EFT accounts (see subpart 32.11) for the same entity.

“Registered in the System for Award Management (SAM) database” means that—

(1) The Offeror has entered all mandatory information, including the unique entity identifier and the EFT indicator, if applicable, the Commercial and Government Entity (CAGE) code, as well as data required by the Federal Funding Accountability and Transparency Act of 2006 (see subpart 4.14) into the SAM database;

(2) The Offeror has completed the Core, Assertions, and Representations and Certifications, and Points of Contact sections of the registration in the SAM database;

(3) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS). The Offeror will be required to provide consent for TIN validation to the Government as a part of the SAM registration process; and

(4) The Government has marked the record “Active”.

“Unique entity identifier” means a number or other identifier used to identify a specific commercial, nonprofit, or Government entity. See www.sam.gov for the designated entity for establishing unique entity identifiers.

(b)(1) By submission of an offer, the Offeror acknowledges the requirement that a prospective awardee shall be registered in the SAM database prior to award, during performance, and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.

(2) The Offeror shall enter, in the block with its name and address on the cover page of its offer, the annotation “Unique Entity Identifier” followed by the unique entity identifier that identifies the Offeror’s name and address exactly as stated in the offer. The Offeror also shall enter its EFT indicator, if applicable. The unique entity identifier will be used by the Contracting Officer to verify that the Offeror is registered in the SAM database.

(c) If the Offeror does not have a unique entity identifier, it should contact the entity designated at www.sam.gov for establishment of the unique entity identifier directly to obtain one.

The Offeror should be prepared to provide the following information:

(1) Company legal business name.

(2) Tradestyle, doing business, or other name by which your entity is commonly recognized.

(3) Company Physical Street Address, City, State, and Zip Code.

(4) Company Mailing Address, City, State and Zip Code (if separate from physical).

(5) Company telephone number.

(6) Date the company was started.

(7) Number of employees at your location.

(8) Chief executive officer/key manager.

(9) Line of business (industry).

(10) Company Headquarters name and address (reporting relationship within your entity).

- (d) If the Offeror does not become registered in the SAM database in the time prescribed by the Contracting Officer, the Contracting Officer will proceed to award to the next otherwise successful registered Offeror.
- (e) Processing time, which normally takes 48 hours, should be taken into consideration when registering. Offerors who are not registered should consider applying for registration immediately upon receipt of this solicitation.
- (f) Offerors may obtain information on registration at <https://www.acquisition.gov>.

6. Section 5.73 Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements

OPM is adding this contract section to Carrier contracts to prohibit restrictions on whistleblowing to the Federal Government and to facilitate flow down into Carrier subcontracts as required by FAR clause 52.244-6.

SECTION 5.73

PROHIBITION ON REQUIRING CERTAIN INTERNAL CONFIDENTIALITY AGREEMENTS OR STATEMENTS (JAN 2017) (FAR 52.203-19)

(a) *Definitions.* As used in this clause—

“Internal confidentiality agreement or statement” means a confidentiality agreement or any other written statement that the contractor requires any of its employees or subcontractors to sign regarding nondisclosure of contractor information, except that it does not include confidentiality agreements arising out of civil litigation or confidentiality agreements that contractor employees or subcontractors sign at the behest of a Federal agency.

“Subcontract” means any contract as defined in subpart 2.1 entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

“Subcontractor” means any supplier, distributor, vendor, or firm (including a consultant) that furnishes supplies or services to or for a prime contractor or another subcontractor.

(b) The Contractor shall not require its employees or subcontractors to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or subcontractors from lawfully reporting waste, fraud, or abuse related to the performance of a Government contract to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information (*e.g.*, agency Office of the Inspector General).

(c) The Contractor shall notify current employees and subcontractors that prohibitions and restrictions of any preexisting internal confidentiality agreements or statements covered by this clause, to the extent that such prohibitions and restrictions are inconsistent with the prohibitions of this clause, are no longer in effect.

(d) The prohibition in paragraph (b) of this clause does not contravene requirements applicable to Standard Form 312 (Classified Information Nondisclosure Agreement), Form

4414 (Sensitive Compartmented Information Nondisclosure Agreement), or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

(e) In accordance with section 743 of Division E, Title VII, of the Consolidated and Further Continuing Appropriations Act, 2015, (Pub. L. 113-235), and its successor provisions in subsequent appropriations acts (and as extended in continuing resolutions) use of funds appropriated (or otherwise made available) is prohibited, if the Government determines that the Contractor is not in compliance with the provisions of this clause.

(f) The Contractor shall include the substance of this clause, including this paragraph (f), in subcontracts under such contracts.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1

ALTERATIONS IN CONTRACT (JAN 2014) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 ~~Plan Performance~~—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b) and (c) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of

Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term “repeated” in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the

Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be

warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2

HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3

DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4

AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the

waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5 ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6 TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

- (i) the actual aggregate charges for those costs, or
- (ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7 MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program

can be identified, or

3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8

PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

- (i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;
- (ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;
- (iii) provide the enrollee with instructions on how to use the waiver, and
- (iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9

SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10

LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11

PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12

TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13

PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR
REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE
(JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}} \right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:

- (a) the rate specified at 26 USC §11 (b) (1) (D),
- (b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
- (c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports \$900 on IRS Form 8963 and pays \$500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$500 HIP Fee, F's Form 8963 reflects that \$300 is attributable to F's FEHBP business.

Also in 2015, G reports \$950 on IRS Form 8963 and pays \$550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$550 HIP Fee, G's Form 8963 reflects that \$325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $\$300 + \$325 = \$725$, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of \$300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: $(\$300/1-.35)-\$300 = \$162$

Local Plan G HIP Tax Cost: $(\$325/1-.20)-\$325 = \$81$

Sum which is C's allowable HIP Tax Cost for 2015 = \$243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of $300 + 325 = \$725$, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
 Local Plan G HIP Tax Cost for 2016 = 0
 Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
 Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes \$162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes \$81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of \$325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as \$325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less \$325.]

Local Plan F HIP Tax Cost for 2017 = 162
 Local Plan G HIP Tax Cost for 2017 = 81
 Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% = 81
 Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = \$324

APPENDIX A

ATTACH

2018 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

(Blue cross and Blue Shield Service Benefit Plan)

CONTRACT NO. CS 1039

Effective January 1, 2018

- (a) Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Standard Option		Basic Option	
Self Only	\$329.24	Self Only	\$283.56
Self Plus One	\$720.01	Self Plus One	\$637.35
Self and Family	\$763.01	Self and Family	\$675.54

- (b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2018,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	[REDACTED]

**The Contractual Expense Limitation for 2018 is [REDACTED] Notwithstanding Section 3.2 (b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act

(Section 2718 of the Public Health Service Act; 42 U.S.C. 300gg-18, and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

Actual Affordable Care Act health insurer's provider fees and the related federal income tax impact related to the reimbursement of the health insurer's provider fee (calculated in accordance with Section 4.14) will be reimbursed and will remain outside the contractual expense limitation for 2018.

** The Service Charge for the 2018 contract year is based on the Overall Performance Score calculated in accordance with the 2017 Appendix F. The Service Charge for the 2019 contract year will be based on the Overall Performance Score calculated in accordance with the 2018 Appendix F.

Appendix E

Subsections (b), (c), (d), (e), (f), (g), (i), (j), (k), and (l) were amended in accordance to the January 2017 CFR 52.219-9. The text of the CFR has been edited consistent with the FEHBP's exception to the requirement that contractors report to eSRS.

APPENDIX E

Small Business Subcontracting Plan (JAN 2017)

(a) This clause does not apply to small business concerns.

(b) *Definitions.* As used in this clause—

“Alaska Native Corporation (ANC)” means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

“Commercial item” means a product or service that satisfies the definition of commercial item in section 2.101 of the Federal Acquisition Regulation.

“Commercial plan” means a subcontracting plan (including goals) that covers the Offeror's fiscal year and that applies to the entire production of commercial items sold by either the entire company or a portion thereof (e.g., division, plant, or product line).

“Indian tribe” means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

“Individual subcontracting plan” means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the Offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

“Master subcontracting plan” means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

“Reduced payment” means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

“Subcontract” means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

“Total contract dollars” means the final anticipated dollar value, including the dollar value of all options.

“Untimely payment” means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c)(1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

(2)(i) The Contractor may accept a subcontractor’s written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor’s representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if—

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The Offeror’s subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626—

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns; and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns.

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (e.g., existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in SAM, as an accurate representation of a concern's size and

ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM, as its source list does not relieve a firm of its responsibilities (e.g., outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

- (i) Small business concerns (including ANC and Indian tribes);
- (ii) Veteran-owned small business concerns;
- (iii) Service-disabled veteran-owned small business concerns;
- (iv) HUBZone small business concerns;
- (v) Small disadvantaged business concerns (including ANC and Indian tribes); and
- (vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of \$700,000 (\$1.5 million for construction of any public facility) with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

- (i) Cooperate in any studies or surveys as may be required;
- (ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;
- (iii) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (1) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (1) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations; and
- (iv) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (1) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (1) of this clause.
- (vi) [RESERVED]; and
- (vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own DUNS number, and the e-mail address of the subcontractor's official

responsible for acknowledging receipt of or rejecting the ISRs, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the Offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.*, SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than \$150,000, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged, service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the Offeror to the Government, including the name, address, and business size of each subcontractor.

Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if—

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial items. The commercial plan shall relate to the Offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial item. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the Offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the Offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Items, or when the subcontractor provides a commercial item subject to the clause at 52.244-6, Subcontracts for Commercial Items, under a prime contract.

(k) The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled "Utilization Of Small Business Concerns," or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. The Contractor shall submit SSRs. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC

or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan. For Contractors the report shall be submitted to the Contracting Officer, or as specified elsewhere in this contract. In the case of a subcontract with a subcontracting plan, the report shall be submitted to the entity that awarded the subcontract.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over \$700,000 (over \$1.5 million for construction of a public facility) and contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F

Measures and contributions to performance areas and scores for 2018 Performance and 2019 Service Charge

To be performed in accordance with the 2018 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the 2019 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Priority Level	Measure Weight
Clinical Quality	Breast Cancer Screening	2	1.25
	Prenatal and Postpartum Care (Timeliness)	1	2.50
	Well Child Visits in the First 15 Months of Life	2	1.25
	Flu Vaccinations for Adults Ages 18-64	2	1.25
	Cervical Cancer Screening	2	1.25
	Controlling High Blood Pressure	1	2.50
	Comprehensive Diabetes Care – HbA1C <8% - Control	2	1.25
	Asthma Medication Ratio	2	1.25
	Medication Management for People with Asthma (75%)	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up After Hospitalization for Mental Illness (7-day or 30-day)	2	1.25
	Plan Information on Costs	3	1.00
Customer Service	Getting Needed Care	3	1.00
	Getting Care Quickly	3	1.00
	Claims Processing	3	1.00
	Overall Health Plan Rating	3	1.00

	Coordination of Care	3	1.00
	Overall Personal Doctor Rating	3	1.00
	Customer Service	3	1.00
Resource Use	Plan All Cause Readmissions	1	2.50
	Use of Imaging Studies for Low Back Pain	2	1.25

Exhibit H

2019A Amendment to Contract No. CS 1039*

**Between the U.S. Office of Personnel Management
and the Blue Cross and Blue Shield Association
on Behalf of, and as Agent for, Participating
Blue Cross and/or Blue Shield Plans**

*In 2013, OPM consolidated prior amendments to Contract No. CS 1039 into one single restated contract.

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2019A
EFFECTIVE: January 1, 2019

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Association
hereafter also called the Carrier

Address: 1310 G. Street, NW, Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

FOR THE GOVERNMENT

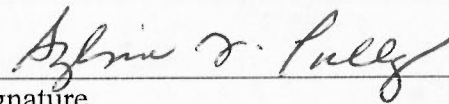
William A. Breskin
Name of Person Authorized to
Execute Contract (Type or print)

Sylvia V. Pulley
Name of Contracting Officer (Type or print)

Senior Vice President, Government
Programs
Title

Contracting Officer
FEHB I
Title


Signature


Signature

12/19/18
Date Signed

12/19/2018
Date Signed

1. Section 1.9 Plan Performance—Fee-For-Service Contracts

We amended Subsection (f) to align quality assurance standards among Carriers and to provide clarity for the measures and standards. Subparagraph (f)(4) *Coordination of Benefits* was moved to its own subsection in Section 1.9(j) because it is a more appropriate location for the requirement. Subsections (j) and (k) were renamed (k) and (l) respectively and references to them were changed accordingly. In amended Subparagraphs (f)(4) *Claims Timeliness* and (f)(6) *Member Inquiries*, the time period for reporting was clarified. In amended Subparagraph (f)(10)(i) *Call Answer Timeliness*, the required standard is set at 85% of calls answered by a live voice (during operating hours) within 30 seconds. In amended Subparagraph (f)(11) *Responsiveness to FEHB Member Requests for Reconsideration*, the reportable calculation is described. The required quality assurance standards are otherwise unchanged in these amendments. Subparagraph (g)(2) *Coordination of Benefits* was moved to its own subsection in Section 1.9(k) because it is a more appropriate location for the requirement; the language was also edited for clarity

SECTION 1.9

PLAN PERFORMANCE—FEE-FOR-SERVICE CONTRACTS (JAN 2019)

* * * * *

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality over the contract period. The Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period:

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed.

REQUIRED STANDARD: The Carrier shall accurately process at least 95 percent of FEHB claims.

(2) *Claims Coding Accuracy* - the number of FEHB claims coded accurately divided by the total number of FEHB claims coded.

REQUIRED STANDARD: The Carrier shall accurately code at least 98 percent of FEHB claims.

(3) *Recovery of Erroneous Payments* - the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier shall average no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Claims Timeliness* - the number of FEHB claims adjudicated (paid, denied, or a request for further information is sent out) within 30 working days from the date the Carrier received the claim, divided by the total number of FEHB claims received.

REQUIRED STANDARD: The Carrier shall adjudicate at least 95 percent of claims within 30 working days.

(5) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier shall issue all ID cards within 15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier shall issue ID cards resulting from an open season election within 15 calendar days or by December 15, whichever is later.

(6) *Member Inquiries* - the number of written inquiries responded to within 15 working days divided by the total number of written inquiries received.

REQUIRED STANDARD: The Carrier shall respond to at least 90 percent of inquiries within 15 working days.

(7) *Written Inquiries Accuracy* - the number of FEHB written inquiries answered accurately divided by the total number of FEHB written inquiries received.

REQUIRED STANDARD: the Carrier shall accurately answer at least 97 percent of FEHB written inquiries.

(8) *Telephone Inquiries Accuracy* - the number of FEHB telephone inquiries answered accurately divided by the total number of FEHB telephone inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB telephone inquiries.

(9) *Internet Inquiries Accuracy* - the number of FEHB Internet inquiries answered accurately divided by the total number of FEHB Internet inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB Internet inquiries.

(10) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) *Call Answer Timeliness* - the percentage of calls answered by a live voice (during operating hours) within 30 seconds.

REQUIRED STANDARD: The Carrier shall answer 80% of telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) *Telephone Blockage Rate* - the number of calls receiving a busy signal when calling the Carrier divided by the total number of calls received.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls receive a busy signal.

(iii) *Telephone Abandonment Rate* - the number of calls attempted but not connected to a live voice divided by the total number of calls attempted.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls are abandoned before connection to a live voice.

(iv) *Initial Call Resolution* - the number of initial calls that result in a resolution of the issue divided by the total number of initial calls for an issue.

REQUIRED STANDARD: The Carrier shall resolve the issue during the initial call at least 80 percent of the time.

(11) *Responsiveness to FEHB Member Requests for Reconsideration* - the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim divided by the total number of requests for reconsideration of disputed claims received.

REQUIRED STANDARD: The Carrier shall respond to 100 percent of written FEHB disputed claim requests within 30 days after receipt by the Carrier.

* * * * *

(j) The Carrier must demonstrate that it uses and shall use a statistically valid sampling technique to identify FEHB claims prior to or after processing that requires coordination of benefits with a third party payer or the Carrier shall pursue and provide evidence that it pursues all claims for coordination of benefits.

(k) *Correction of Deficiencies*. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided

the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(l) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (k).

2. Section 1.26 Standards for Pharmacy Benefit Management Company (PBM) Arrangements

We amended Subsection (c) to update the references to Section 1.9, Subsection (f).

SECTION 1.26

STANDARDS FOR PHARMACY BENEFIT MANAGEMENT COMPANY (PBM) ARRANGEMENTS (JAN 2019)

* * * * *

(c) Performance Standards The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, telephone customer service, paper claims processing, and other applicable standards set for Carriers at Section 1.9(f)(1), (2), (4), (6), and (10). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBM's book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

* * * * *

3. Section 1.30 Health Information Technology Privacy and Security

We amended Subsection (d) to more clearly require Carriers to allow an authorized representative of the Contracting Officer to perform independent evaluations to ensure information systems that directly process FEHBP data and information systems that are in the same general IT control environment are securely configured and are up to date.

SECTION 1.30

HEALTH INFORMATION TECHNOLOGY PRIVACY AND SECURITY (JAN 2019)

(a) Any Carrier subcontractor, large provider, or vendor, that administers a personal health record or quality and cost or price transparency software applications for Members that collect, create, receive, store or transmit individually identifiable protected health information of

Members that does not qualify as a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or regulations will be required by the Carrier to, at a minimum, comply with equivalent privacy and security policies as are required of a “covered entity” under the HIPAA Privacy and Security regulations.

(b) The Carrier will provide for consumer transparency including, but not limited to, the posting of the subcontractor’s, large provider’s, or vendor’s notice of privacy practices prominently at the point where the Member enters the subcontractor’s, large provider’s, vendor’s or other entity’s website or web portal.

(c) Notices of privacy practices disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier must allow the Contracting Officer or an authorized representative of the Contracting Officer to independently perform credentialed vulnerability scans and configuration compliance audits (using administrator accounts) against the Carrier’s information systems and environments described in this subsection to determine whether the Carrier has controls in place to ensure its information systems are securely configured and patches are timely applied and up to date based on the level of risk in the environment.

(1) NIST SP 800-53 (or its current equivalent) may be used as a benchmark for conducting audits of Carrier information systems. The Contracting Officer or an authorized representative of the Contracting Officer may recommend that the Carrier adopt a best practice drawn from NIST SP 800-53 (or its current equivalent) to the following Carrier information systems:

(i) Information systems that directly process FEHBP data for contract purposes;
and

(ii) All other information systems operating in the same general information technology control environment (i.e. any resources in the same physical or logical environment) as the information systems in subparagraph (i) above.

(2) In a written response to such a recommendation, the Carrier shall do one of the following:

(i) Agree to adopt the recommendation,

(ii) Explain that it is already in compliance with the recommendation, or

(iii) Explain why maintaining its current practice is compliant with Section 1.22, captioned Administrative Simplification -- HIPAA and is equally, if not more, appropriate for its business purposes than the recommended best practice from (1) above.

(3) Upon request of the Contracting Officer or an authorized representative of the Contracting Officer, the Carrier agrees to demonstrate to the requestor its compliance with either a recommended best practice from (1) or an alternative current practice from subparagraph (2)(iii) that the Carrier has adopted. Evidence submitted pursuant to (2) that the Carrier and Contracting Officer agree is extremely sensitive may, at the Carrier's request and the Contracting Officer's concurrence, be reviewed on the Carrier's premises.

(4) If the Carrier agrees to adopt a best practice recommendation made pursuant to (1) above, the Contracting Officer will allow reasonable time for the Carrier to implement the best practice before making any request under (3) above.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1

ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) ~~Section 1.9 Plan~~ Performance—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) ~~Except~~ as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2

HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3

DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4

AUDIT DISPUTES (JAN 2000)

- (a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.
- (b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.
- (c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5

ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6

TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

- (i) the actual aggregate charges for those costs, or
- (ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7

MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8

PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9

SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10

LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11

PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12

TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13

PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}} \right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:

(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or

(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports \$900 on IRS Form 8963 and pays \$500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$500 HIP Fee, F's Form 8963 reflects that \$300 is attributable to F's FEHBP business.

Also in 2015, G reports \$950 on IRS Form 8963 and pays \$550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$550 HIP Fee, G's Form 8963 reflects that \$325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $\$300 + \$325 = \$725$, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of \$300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: $(\$300/1-.35)-\$300 = \$162$

Local Plan G HIP Tax Cost: $(\$325/1-.20)-\$325 = \$81$

Sum which is C's allowable HIP Tax Cost for 2015 = \$243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of $300 + 325 = \$725$, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162

Local Plan G HIP Tax Cost for 2016 = 0

Reimbursement attributable to G = adjustment for amounts drawn down by C, if any

Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes \$162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes \$81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of \$325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as \$325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less \$325.]

Local Plan F HIP Tax Cost for 2017 = 162

Local Plan G HIP Tax Cost for 2017 = 81

Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% = 81

Sum = C's allowable HIP Tax Cost for 2017 = $162 + 81 + 81 = \$324$

APPENDIX A

2019

Brochure Text

For a copy of the 2009 brochure, please go to
<https://bluewebportal.bcbs.com/>

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

Blue Cross and Blue Shield Service Benefit Plan

CONTRACT NO. CS 1039

Effective January 1, 2019

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Basic Option: \$283.56 Self, \$637.35 Self Plus One, and \$675.54 Self and Family
 Standard Option: \$329.24 Self, \$720.01 Self Plus One, and \$763.01 Self and Family
 FEP Blue Focus: \$204.40 Self, \$439.44 Self Plus One, and \$483.37 Self and Family

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

<u>Item</u>	<u>Amount</u>
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2019,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	Redacted

*The Contractual Expense Limitation for 2019 is Redacted Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the

Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2019 contract year is based on the Overall Performance Score calculated in accordance with the 2018 Appendix F. The Service Charge for the 2020 contract year will be based on the Overall Performance Score calculated in accordance with the 2019 Appendix F.

APPENDIX D
RULES FOR COORDINATION OF BENEFITS

Model Regulation Service--October 2013

National Association of Insurance Commissioners

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

- A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.
- (2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.
- (3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one Carrier pays or provides benefits under the plan, the Carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.
- (4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.
- B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

Drafting Note: The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts (often referred to as "med pay"), which is included in the definition of "plan" under Section 3K(3) of this model regulation, does not normally contain order of benefit determinations provisions. As such, unless state law or regulation specifies otherwise, in accordance with paragraph (1), such coverage would be primary. Med pay coverage is not liability coverage and is not dependent upon fault.

- (2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage's that are superimposed over base plan hospital and surgical benefits, and insurance type coverage's that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

- (a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

- (b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (I) Secondary to the plan covering the person as a dependent; and

- (II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

- (ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1)

Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
- (b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or
- (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (I) The plan covering the custodial parent;
 - (II) The plan covering the custodial parent's spouse;
 - (III) The plan covering the non-custodial parent; and then
 - (IV) The plan covering the non-custodial parent's spouse.
- (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of

benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

(d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parents(s) and the dependent's spouse.

Drafting Note: Subparagraph (d) is intended to address the situation created by the enactment of Section 2714 of the Public Health Service Act, as that section was added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) (ACA), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Section 2714 of the PHSA extended coverage for dependents to age 26 regardless of any dependency factors, such as support, residency, student status or marital status.

(3) Active Employee or Retired or Laid-Off Employee

- (a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
- (b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

Drafting Note: This rule applies only in the situation when the same person is covered under two plans, one of which is provided on the basis of active employment and the other of which is provided to retired or laid-off employees. The rule in Paragraph (1) does not apply because the person is covered either as a non-dependent under both plans (i.e. the person is covered under one plan as an active employee and at the same time is covered as a retired or laid-off employee under the other plan) or as a dependent under both plans (i.e. the person is covered under one plan as a dependent of an active employee and at the same time is covered under the other plan as a dependent of a retired or laid-off employee). This rule does not apply when a person is covered under his or her own plan as an active employee or retired or laid-off employee and a dependent under a spouse's plan provided to the spouse on the basis of active employment. In this situation,

the rule in Paragraph (1) applies because the person is covered as a non-dependent under one plan (i.e. the person is covered as an active employee or retired or laid-off employee) and at the same time is covered as a dependent under the other plan (i.e. the person is covered as a dependent under a plan provided on the basis of active employment or a plan that is provided to retired or laid-off employees).

(4) COBRA or State Continuation Coverage

- (a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
- (b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

Drafting Note: COBRA originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), allows the COBRA coverage to continue if the newly acquired group health plan contains any preexisting condition exclusion or limitation. In this instance two group health plans will cover the person, and the rule above will be used to determine which of the plans determines its benefits first. In addition, some states have continuation provisions comparable to COBRA.

Drafting Note: This rule applies only in the situation when a person has coverage pursuant to COBRA or under a right of continuation pursuant to state or other federal law and has coverage under another plan on the basis of employment. The rule under Paragraph (1) does not apply because the person is covered either: (a) as a non-dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). The rule under Paragraph (1) applies when the person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law as a non-dependent and covered under the other plan as a

dependent of an employee, member, subscriber or retiree. The rule in this paragraph does not apply because the person is covered as a non-dependent under one of the plans and as a dependent under the other plan.

(5) Longer or Shorter Length of Coverage

- (a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
 - (b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
 - (c) The start of a new plan does not include:
 - (i) A change in the amount or scope of a plan's benefits;
 - (ii) A change in the entity that pays, provides or administers the plan's benefits; or
 - (iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
 - (d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
- (6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

APPENDIX F

Measures and contributions to performance areas and scores for 2019 Performance and 2020 Service Charge

To be performed in accordance with the 2019 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the 2020 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	1	2.50
	Prenatal Care (Timeliness)	1	2.50
	Breast Cancer Screening	2	1.25
	Well Child Visits in the First 15 Months of Life (6 visits)	2	1.25
	Flu Vaccinations for Adults (18-64)	2	1.25
	Cervical Cancer Screening	2	1.25
	Comprehensive Diabetes Care – HbA1C <8% - Control	2	1.25
	Asthma Medication Ratio	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up After Hospitalization for Mental Illness (7-day or 30-day)	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	2	1.25
	Plan Information on Costs	3	1.00
Customer Service	Getting Care Quickly	3	1.00
	Getting Needed Care	3	1.00
	Claims Processing	3	1.00
	Overall Health Plan Rating	3	1.00
	Coordination of Care	3	1.00

	Overall Personal Doctor Rating	3	1.00
	Customer Service	3	1.00
Resource Use	Plan All Cause Readmissions	1	2.50
	Emergency Department Utilization	2	1.25
	Use of Imaging Studies for Low Back Pain	2	1.25

Exhibit I

2020A Amendment to Contract No. CS 1039

**Between the U.S. Office of Personnel Management
and the Blue Cross and Blue Shield Association
on Behalf of, and as Agent for, Participating
Blue Cross and/or Blue Shield Plans**

AMENDMENT TO CONTRACT CS XXXX

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2020A
EFFECTIVE: January 1, 2020

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G. Street. NW, Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

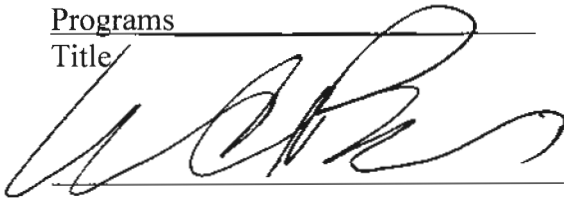
FOR THE GOVERNMENT

William A. Breskin
Name of Person Authorized to
Execute Contract (Type or print)

Sylvia V. Pulley
Name of Contracting Officer (Type or print)

Senior Vice President, Government
Programs
Title

Contracting Officer
FEHB I
Title



Signature

Signature

12/16/19
Date Signed

12/17/2019
Date Signed

1. Section 1.9 Plan Performance

We amended the last sentence in subsection (b) to clarify that the referenced costs are allowable administrative expenses, subject to the administrative cost limitation.

SECTION 1.9 PLAN PERFORMANCE--EXPERIENCE-RATED FFS CONTRACTS (JAN 2020)

* * * * *

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare Effectiveness Data and Information Set (HEDIS), measures developed by the Pharmacy Quality Alliance (PQA), and similar measures developed by accrediting organizations such as, but not limited to, the Association for Ambulatory Health Care (AAAH), the National Committee for Quality Assurance (NCQA), and URAC or endorsed by the National Quality Forum. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data are allowable administrative expenses, subject to the administrative cost limitation.

* * * * *

2. Section 1.26 FFS Standards For Pharmacy Benefit Management Company (PBM) Arrangements

We amended the language in this section to better align the contract with industry standards. The title was updated to reflect the updated terminology and changes were made based on the March 2013 conversion. This section was amended to make it generally applicable to any vendor providing PBM services. In subsection (a) definitions were added. Subsection (b)(2)(i) was amended to mitigate matters with aggregate pricing/reimbursement. Subsection 4 was amended to ensure that disclosure of fees is not limited to administrative fees. Subsection (b)(7) was amended to ensure that OPM is able to request reports or information about PBMs through the Carrier if the Carrier does not have requested information. Subsection (c) was amended to include all integrity standards related to a Carrier PBM contract. Subsection (d) was amended to remove paragraph-level cross-references to section 1.9, given that some text does not correspond to all listed cross-references. Technical edits were made in subsection (e) to replace “physician” with “Prescriber” as other providers may be able to write prescriptions. Subsection (f) was added to allow for prior approval. Subsection (g) was amended to track the URAC standard.

SECTION 1.26 STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2020)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family members effective on or after January 1, 2020. Notwithstanding the foregoing, the revisions to Section 1.26 shall not take effect before the expiration of the Carrier’s current

contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2023. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.26.

If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.26 shall be deemed to be references to the Underwriter.

(a) Definitions Under This Section

(1) "Expedited request" means a request initiated by the Prescriber or member when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient's life, health, or ability to regain maximum function.

(2) "Licensed pharmacist" means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction's laws and regulations.

(3) "Manufacturer payment" means any and all compensation, financial benefits, or remuneration the PBM receives from a pharmaceutical manufacturer for any dispensing or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, and any fees received for sales of utilization data to a pharmaceutical manufacturer.

(4) "Net revenue" means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail networks or PBM-owned or controlled mail order pharmacies, that is allocable to the Plan for the reporting period.

(5) "Network pharmacy," means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.

(6) "Pass through transparent pricing" means drug pricing in which the Carrier receives the full value of the PBM's negotiated discounts, rebates, credits, or other financial benefits.

(7) "Pharmacy Benefit Manager" or "PBM" means the combination of

(i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs; and

(ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).

(8) "Prescriber" means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.

(9) "Total product revenue" means the total dollar sales of prescription drugs to clients, either through retail networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM's entire client base, for the reporting period.

(b) Transparency Standards

(1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM shall agree to provide pass-through transparent pricing based on the PBM's cost for drugs (as described below).

(i) The PBM shall charge the Carrier no more than the amount paid to the retail pharmacy for each drug plus a dispensing fee.

(ii) The PBM shall charge the Carrier the cost of drugs dispensed by a specialty and/or a mail order pharmacy that is owned by the PBM based on the pharmacy's actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks; for example, Average Acquisition Cost (AAC) or Wholesale Acquisition Cost (WAC).

(iii) The PBM, or any other entity that negotiates and collects Manufacturer

Payments

allocable to the Carrier, agrees to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocated to the Carrier.

(3) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(4) All of the PBM's fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM.

(5) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a mail order pharmacy, and its retail network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75 percent of the total cost to the Carrier, whichever is the greater number:

(i) the dollar amount of Total Product Revenue;

(ii) the dollar amount of total drug expenditures for the Plan;

(iii) the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;

(iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.

(v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers;

(vi) the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(6) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible

Enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier.

(7) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. At OPM's request, the Carrier must obtain from the PBM any reasonable information or reports and provide it to OPM. A PBM providing information to a Carrier under this subsection may designate that information as confidential commercial information. The Carrier in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential under 5 C.F.R. § 294.112.

(8) The Carrier will require that its PBM:

- (i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;
- (ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and
- (iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(9) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG). The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

- (i) All PBM contracts with Participating Pharmacies, including invoices, receipts, and credits;
- (ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;
- (iii) All PBM contracts with third parties purchasing or using claims data;
- (iv) All PBM transmittals in connection with sales of claims data to third parties; and
- (v) All PBM Maximum Allowable Cost (MAC) price lists.

(c) Integrity Standards

- (1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the most recent Code of Ethics of the American Pharmacists Association, for their employed pharmacists.
- (2) The Carrier will require that its PBM be licensed as required by the appropriate jurisdiction's laws and regulations.
- (3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.
- (4) A PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.
- (5) A PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.

- (6) A PBM, or Carrier, shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:
- (i) The cost of a prescription medication to the member; or
 - (ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, customer service, claims processing, and other applicable standards set for Carriers at Section 1.9(f). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

- (1) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to network pharmacies.
- (2) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, network pharmacies.
- (3) Licensing. The PBM verifies the appropriate licensing of its network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.
- (4) Dispensing accuracy. The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.
- (5) Mail service pharmacy turnaround time. The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.
- (6) Quality of Drug Therapy. The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to Enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Alternative Drug Options – The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

- (1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the

patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.

(2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other office staff member as authorized by the Prescriber.

(3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescriber's office and the basis for his or her authority.

(4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.

(5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.

(6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(f) Utilization Management Timeframe – The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.

(1) For expedited requests, the PBM must review and respond within 24 hours.

(2) For other, non-expedited requests, the PBM must review and respond within 72 hours.

(g) Patient Safety Standard - The Carrier will require that its PBM contractors establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

- (i) A system for identifying and communicating drug and consumer safety issues at point-of-service;
- (ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer;
- (iii) A system/process for error reporting; and
- (iv) A system/process for identifying/managing risk

(h) Safety and Accessibility for Consumers - The Carrier will require that its PBM meets the following standards related to pharmacy network management and consumer access to medications.

(1) The Carrier will require that its PBM contractor define the scope of its services with respect to:

- (i) The distribution channels offered (e.g. pharmacy network, mail order pharmacies, or specialty pharmacies);
- (ii) The types of pharmacy services offered within each distribution channel; and
- (iii) The geographic area served by each distribution channel.

(2) The Carrier will require that for each distribution channel provided by its PBM contractor, the PBM contractor:

- (i) Establishes criteria and measures actual performance in comparison to those criteria; and
- (ii) Makes improvements where necessary to maintain the pharmacy network and meet contractual requirements.

(3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:

- (i) Quality and safety of drug distribution; and
- (ii) Quality of service.

(i) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

3. Section 2.2 Benefits Provided

This section is amended to reflect recognition of the fact that a number of judicial jurisdictions have determined section 501 to be the provision of the Rehabilitation Act of 1973 that is appropriately applicable to individuals covered under the FEHB Program.

SECTION 2.2 BENEFITS PROVIDED (JAN 2020)

* * * * *

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c) The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with the Rehabilitation Act of 1973, in the case of a Member who is a qualified individual with a disability, the Carrier shall pay for or provide a covered health service or supply as an alternative benefit appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

* * * * *

4. Section 5.14 Utilization Of Small Business Concerns

We have updated this section consistent with the updated FAR clause.

SECTION 5.14 UTILIZATION OF SMALL BUSINESS CONCERNS (OCT 2018) (FAR 52.219-8)

(a) Definitions. As used in this contract --

“HUBZone small business concern” means a small business concern, certified by the Small Business Administration, that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.

“Service-disabled veteran-owned small business concern”

(1) Means a small business concern—

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

“Small business concern” means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

“Small disadvantaged business concern”, consistent with 13 CFR 124.1002, means a small business concern under the size standard applicable to the acquisition, that--

(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—

(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and

(ii) Each individual claiming economic disadvantage has a net worth not exceeding \$750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition.

“Veteran-owned small business concern” means a small business concern—

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

“Women-owned small business concern” means a small business concern—

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(c) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(d)(1) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, a veteran-owned small business, service-disabled veteran-owned small business or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(2) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if—

(i) The subcontractor is registered in SAM; and
(ii) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(3) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(4) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(5) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the System for Award Management or by contacting the SBA. Options for contacting the SBA include—

(i) HUBZone small business database search application web page at http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or <http://www.sba.gov/hubzone>;

(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or

The SBA HUBZone Help Desk at hubzone@sba.gov.

5. Section 5.18 Contract Work Hours And Safety Standards Act -- Overtime Compensation

We amended subsection (b) to remove specific dollar amounts for liability and provisions of the law which were added to provide guidance for monetary penalties of inflation.

SECTION 5.18 CONTRACT WORK HOURS AND SAFETY STANDARDS ACT -- OVERTIME COMPENSATION (MAY 2018) (FAR 52.222-4)

(a) *Overtime requirements.* No Contractor or subcontractor employing laborers or mechanics (see Federal Acquisition Regulation 22.300) shall require or permit them to work over 40 hours in any workweek unless they are paid at least 1 and ½ times the basic rate of pay for each hour worked over 40 hours.

(b) *Violation; liability for unpaid wages; liquidated damages.* The responsible Contractor and subcontractor are liable for unpaid wages if they violate the terms in paragraph (a) of this clause. In addition, the Contractor and subcontractor are liable for liquidated damages payable to the Government. The Contracting Officer will assess liquidated damages at the rate specified at 29 CFR 5.5(b)(2) per affected employee for each calendar day on which the employer required or permitted the employee to work in excess of the standard workweek of 40 hours without paying overtime wages required by the Contract Work Hours and Safety Standards statute (found at 40 U.S.C. chapter 37). In accordance with the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note), the Department of Labor adjusts this civil monetary penalty for inflation no later than January 15 each year.

(c) *Withholding for unpaid wages and liquidated damages.* The Contracting Officer will withhold from payments due under the contract sufficient funds required to satisfy any Contractor or subcontractor liabilities for unpaid wages and liquidated damages. If amounts withheld under the contract are insufficient to satisfy Contractor or subcontractor liabilities, the Contracting Officer will withhold payments from other Federal or Federally assisted contracts held by the same Contractor that are subject to the Contract Work Hours and Safety Standards statute.

(d) *Payrolls and basic records.* (1) The Contractor and its subcontractors shall maintain payrolls and basic payroll records for all laborers and mechanics working on the contract during the contract and shall make them available to the Government until 3 years after contract completion. The records shall contain the name and address of each employee, social security

number, labor classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records need not duplicate those required for construction work by Department of Labor regulations at 29 CFR 5.5(a)(3) implementing the Construction Wage Rate Requirements statute.

(2) The Contractor and its subcontractors shall allow authorized representatives of the Contracting Officer or the Department of Labor to inspect, copy, or transcribe records maintained under paragraph (d)(1) of this clause. The Contractor or subcontractor also shall allow authorized representatives of the Contracting Officer or Department of Labor to interview employees in the workplace during working hours.

(e) *Subcontracts*. The Contractor shall insert the provisions set forth in paragraphs (a) through (d) of this clause in subcontracts that may require or involve the employment of laborers and mechanics and require subcontractors to include these provisions in any such lower tier subcontracts. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraphs (a) through (d) of this clause.

6. Section 5.58 Payment By Electronic Funds Transfer–System For Award Management

This section was updated to remove the word “database” when referring to accessing the System for Award Management (SAM).

SECTION 5.58 PAYMENT BY ELECTRONIC FUNDS TRANSFER–SYSTEM FOR AWARD MANAGEMENT (OCT 2018) (FAR 52.232-33)

(a) Method of payment.

(1) All payments by the Government under this contract shall be made by electronic funds transfer (EFT), except as provided in paragraph (a)(2) of this clause. As used in this clause, the term “EFT” refers to the funds transfer and may also include the payment information transfer.

(2) In the event the Government is unable to release one or more payments by EFT, the Contractor agrees to either—

- (i) Accept payment by check or some other mutually agreeable method of payment; or
- (ii) Request the Government to extend the payment due date until such time as the Government can make payment by EFT (but see paragraph (d) of this clause).

(b) *Contractor's EFT information*. The Government shall make payment to the Contractor using the EFT information contained in the System for Award Management (SAM). In the event that the EFT information changes, the Contractor shall be responsible for providing the updated information to SAM.

(c) *Mechanisms for EFT payment*. The Government may make payment by EFT through either the Automated Clearing House (ACH) network, subject to the rules of the National Automated Clearing House Association, or the Fedwire Transfer System. The rules governing Federal payments through the ACH are contained in 31 CFR Part 210.

(d) *Suspension of payment*. If the Contractor's EFT information in SAM is incorrect, then the Government need not make payment to the Contractor under this contract until correct EFT information is entered into SAM; and any invoice or contract financing request shall be deemed not to be a proper invoice for the purpose of prompt payment under this contract. The

prompt payment terms of the contract regarding notice of an improper invoice and delays in accrual of interest penalties apply.

(e) Liability for uncompleted or erroneous transfers.

(1) If an uncompleted or erroneous transfer occurs because the Government used the Contractor's EFT information incorrectly, the Government remains responsible for—

(i) Making a correct payment;

(ii) Paying any prompt payment penalty due; and

(iii) Recovering any erroneously directed funds.

(2) If an uncompleted or erroneous transfer occurs because the Contractor's EFT information was incorrect, or was revised within 30 days of Government release of the EFT payment transaction instruction to the Federal Reserve System, and—

(i) If the funds are no longer under the control of the payment office, the Government is deemed to have made payment and the Contractor is responsible for recovery of any erroneously directed funds; or

(ii) If the funds remain under the control of the payment office, the Government shall not make payment, and the provisions of paragraph (d) of this clause shall apply.

(f) *EFT and prompt payment.* A payment shall be deemed to have been made in a timely manner in accordance with the prompt payment terms of this contract if, in the EFT payment transaction instruction released to the Federal Reserve System, the date specified for settlement of the payment is on or before the prompt payment due date, provided the specified payment date is a valid date under the rules of the Federal Reserve System.

(g) *EFT and assignment of claims.* If the Contractor assigns the proceeds of this contract as provided for in the assignment of claims terms of this contract, the Contractor shall require as a condition of any such assignment, that the assignee shall register separately in SAM and shall be paid by EFT in accordance with the terms of this clause. Notwithstanding any other requirement of this contract, payment to an ultimate recipient other than the Contractor, or a financial institution properly recognized under an assignment of claims pursuant to Subpart 32.8, is not permitted. In all respects, the requirements of this clause shall apply to the assignee as if it were the Contractor. EFT information that shows the ultimate recipient of the transfer to be other than the Contractor, in the absence of a proper assignment of claims acceptable to the Government, is incorrect EFT information within the meaning of paragraph (d) of this clause.

(h) *Liability for change of EFT information by financial agent.* The Government is not liable for errors resulting from changes to EFT information made by the Contractor's financial agent.

(i) *Payment information.* The payment or disbursing office shall forward to the Contractor available payment information that is suitable for transmission as of the date of release of the EFT instruction to the Federal Reserve System. The Government may request the Contractor to designate a desired format and method(s) for delivery of payment information from a list of formats and methods the payment office is capable of executing. However, the Government does not guarantee that any particular format or method of delivery is available at any particular payment office and retains the latitude to use the format and delivery method most convenient to the Government. If the Government makes payment by check in accordance with paragraph (a) of this clause, the Government shall mail the payment information to the remittance address contained in SAM.

7. Section 5.60 Subcontracts For Commercial Items

We added subsections (b)(v) and (b)(vi) to include the Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities, and the Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. All other amendments are technical edits to keep the flow and order of the subsections and to update dates to referenced FAR Clauses.

SECTION 5.60 SUBCONTRACTS FOR COMMERCIAL ITEMS (AUG 2019) (FAR 52.244-6)

(a) Definitions. As used in this clause —

“Commercial item” and “commercially available off-the-shelf item” have the meanings contained in Federal Acquisition Regulation 2.101, Definitions.

“Subcontract” includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Oct 2015) (41 U.S.C. 3509), if the subcontract exceeds \$5.5 million and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems (June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (Jul 2018) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (Aug 2019) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (Oct 2018) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds \$700,000 (\$1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015).

(ix) 52.222-26, Equal Opportunity (Apr 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Oct 2015) (38 U.S.C. 4212(a)).

- (xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jul 2014) (29 U.S.C. 793).
- (xii) 52.222-37, Employment Reports on Veterans (Feb 2016) (38 U.S.C. 4212).
- (xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.
- (xiv)(A) 52.222-50, Combating Trafficking in Persons (Jan 2019) (22 U.S.C. chapter 78 and E.O. 13627).
- (B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).
- (xv) 52.222-55, Minimum Wages under Executive Order 13658 (Dec 2015), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.
- (xvi) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.
- (xvii)(A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).
- (B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).
- (xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).
- (xvix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.
- (xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).
- (2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.
- (d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

8. Section 5.63 System For Award Management

We amended subsection (b)(1) to reflect the updated FAR Clause requiring registration in System for Award Management (SAM) when submitting an offer and the continuation of registration throughout the duration of the award.

SECTION 5.63 SYSTEM FOR AWARD MANAGEMENT (OCT 2018) (FAR 52.204-7)

(a) Definitions. As used in this provision—

“Electronic Funds Transfer (EFT) indicator” means a four-character suffix to the unique entity identifier. The suffix is assigned at the discretion of the commercial, nonprofit, or Government entity to establish additional System for Award Management records for identifying alternative EFT accounts (see subpart 32.11) for the same entity.

“Registered in the System for Award Management (SAM) database” means that—

(1) The Offeror has entered all mandatory information, including the unique entity identifier and the EFT indicator, if applicable, the Commercial and Government Entity (CAGE)

code, as well as data required by the Federal Funding Accountability and Transparency Act of 2006 (see subpart 4.14) into SAM;

(2) The offeror has completed the Core, Assertions, and Representations and Certifications, and Points of Contact sections of the registration in SAM;

(3) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS). The offeror will be required to provide consent for TIN validation to the Government as a part of SAM registration process; and

(4) The Government has marked the record “Active”.

“Unique entity identifier” means a number or other identifier used to identify a specific commercial, nonprofit, or Government entity. See www.sam.gov for the designated entity for establishing unique entity identifiers.

(b)(1) An Offeror is required to be registered in SAM when submitting an offer or quotation, and shall continue to be registered until time of award, during performance, and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.

(2) The Offeror shall enter, in the block with its name and address on the cover page of its offer, the annotation “Unique Entity Identifier” followed by the unique entity identifier that identifies the Offeror’s name and address exactly as stated in the offer. The Offeror also shall enter its EFT indicator, if applicable. The unique entity identifier will be used by the Contracting Officer to verify that the Offeror is registered in SAM.

(c) If the Offeror does not have a unique entity identifier, it should contact the entity designated at www.sam.gov for establishment of the unique entity identifier directly to obtain one.

The Offeror should be prepared to provide the following information:

- (1) Company legal business name.
- (2) Tradestyle, doing business, or other name by which your entity is commonly recognized.
- (3) Company Physical Street Address, City, State, and Zip Code.
- (4) Company Mailing Address, City, State and Zip Code (if separate from physical).
- (5) Company telephone number.
- (6) Date the company was started.
- (7) Number of employees at your location.
- (8) Chief executive officer/key manager.
- (9) Line of business (industry).
- (10) Company Headquarters name and address (reporting relationship within your entity).

(d) If the Offeror does not become registered in SAM in the time prescribed by the Contracting Officer, the Contracting Officer will proceed to award to the next otherwise successful registered Offeror.

9. Section 5.66 Updates Of Publicly Available Information Regarding Responsibility Matters

This section was updated to the October 2018 FAR clause which updated the System for Award Management website and removed the word “database.”

SECTION 5.66 UPDATES OF PUBLICALLY AVAILABLE INFORMATION REGARDING RESPONSIBILITY MATTERS (OCT 2018) (FAR 52.209-9)

(a) The Contractor shall update the information in the Federal Awardee Performance and Integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the System for Award Management via <https://www.sam.gov>.

(b) As required by section 3010 of the Supplemental Appropriations Act, 2010 (Pub. L. 111-212), all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available. FAPIIS consists of two segments—

(1) The non-public segment, into which Government officials and the Contractor post information, which can only be viewed by—

(i) Government personnel and authorized users performing business on behalf of the Government; or

(ii) The Contractor, when viewing data on itself; and

(2) The publicly-available segment, to which all data in the non-public segment of FAPIIS is automatically transferred after a waiting period of 14 calendar days, except for—

(i) Past performance reviews required by subpart 42.15;

(ii) Information that was entered prior to April 15, 2011; or

(iii) Information that is withdrawn during the 14-calendar-day waiting period by the Government official who posted it in accordance with paragraph (c)(1) of this clause.

(c) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(1) If the Contractor asserts in writing within 7 calendar days, to the Government official who posted the information, that some of the information posted to the non-public segment of FAPIIS is covered by a disclosure exemption under the Freedom of Information Act, the Government official who posted the information must within 7 calendar days remove the posting from FAPIIS and resolve the issue in accordance with agency Freedom of Information procedures, prior to reposting the releasable information. The contractor must cite 52.209-9 and request removal within 7 calendar days of the posting to FAPIIS.

(2) The Contractor will also have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i.e., for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3) As required by section 3010 of Pub. L. 111-212, all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available.

(d) Public requests for system information posted prior to April 15, 2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures promulgated under E.O. 12600.

10. Section 5.71 Combating Trafficking In Persons

Section 5.71 was updated to reflect the January 2019 FAR clause changes which provide expanded regulations on Human Trafficking.

SECTION 5.71 COMBATING TRAFFICKING IN PERSONS (JAN 2019) (FAR 52.222-50)

(a) Definitions. As used in this clause—

“Agent” means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.

“Coercion” means—

(1) Threats of serious harm to or physical restraint against any person;

(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

(3) The abuse or threatened abuse of the legal process.

“Commercially available off-the-shelf (COTS) item” means-

(1) Any item of supply (including construction material) that is-

(i) A commercial item (as defined in paragraph (1) of the definition at FAR 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

“Commercial sex act” means any sex act on account of which anything of value is given to or received by any person.

“Debt bondage” means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

“Employee” means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.

“Forced labor” means knowingly providing or obtaining the labor or services of a person—

(1) By threats of serious harm to, or physical restraint against, that person or another person;

(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or

(3) By means of the abuse or threatened abuse of law or the legal process.

“Involuntary servitude” includes a condition of servitude induced by means of—

(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or

(2) The abuse or threatened abuse of the legal process.

“Recruitment fees” means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.

(1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

(i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;

- (ii) Advertising;
- (iii) Obtaining permanent or temporary labor certification, including any associated fees;
- (iv) Processing applications and petitions;
- (v) Acquiring visas, including any associated fees;
- (vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;
- (vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;
- (viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;
- (ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;
- (x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;
- (xi) Transportation and subsistence costs—
 - (A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and
 - (B) From the airport or disembarkation point to the worksite;
- (xii) Security deposits, bonds, and insurance; and
- (xiii) Equipment charges.

(2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—

- (i) Paid in property or money;
- (ii) Deducted from wages;
- (iii) Paid back in wage or benefit concessions;
- (iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or
- (v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—
 - (A) Agents;
 - (B) Labor brokers;
 - (C) Recruiters;
 - (D) Staffing firms (including private employment and placement firms);
 - (E) Subsidiaries/affiliates of the employer;
 - (F) Any agent or employee of such entities; and
 - (G) Subcontractors at all tiers.

“Severe forms of trafficking in persons” means—

(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

“Sex trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;

(2) Procure commercial sex acts during the period of performance of the contract; or

(3) Use forced labor in the performance of the contract.

(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee's identity or immigration documents, such as passports or drivers' licenses, regardless of issuing authority;

(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant costs to be charged to the employee or potential employee, and, if applicable, the hazardous nature of the work;

(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;

(6) Charge employees or potential employees recruitment fees;

(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-

(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or

(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that-

(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-

(A) Legally permitted to remain in the country of employment and who chooses to do so; or

(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;

(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.

(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or

(9) If required by law or contract, fail to provide an employment contract, recruitment agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee

relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) *Notification.*

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i) Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud); and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) *Remedies.* In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) Mitigating and aggravating factors. When determining remedies, the Contracting Officer may consider the following:

(1) Mitigating factors. The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has

taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.

(2) Aggravating factors. The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.

(g) Full cooperation.

(1) The Contractor shall, at a minimum-

(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;

(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;

(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and

(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.

(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-

(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;

(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or

(iii) Restrict the Contractor from-

(A) Conducting an internal investigation; or

(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

(h) Compliance plan.

(1) This paragraph (h) applies to any portion of the contract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds \$500,000.

(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-

(i) To the size and complexity of the contract; and

(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.

(3) Minimum requirements. The compliance plan must include, at a minimum, the following:

(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can

be found at the website for the Department of State's Office to Monitor and Combat Trafficking in Persons at <http://www.state.gov/j/tip/>.

(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888-FREE and its email address at help@befree.org.

(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employee or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.

(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.

(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.

(4) Posting.

(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.

(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.

(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-

(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and

(ii) After having conducted due diligence, either-

(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or

(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.

(i) *Subcontracts.*

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-

(A) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(B) Has an estimated value that exceeds \$500,000.

(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

11. Section 5.74 Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities

This is a new section added to the contract to provide rules on the Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab.

SECTION 5.74 PROHIBITION ON CONTRACTING FOR HARDWARE, SOFTWARE, AND SERVICES DEVELOPED OR PROVIDED BY KASPERSKY LAB AND OTHER COVERED ENTITIES (JUL 2018) (FAR 52.204-23).

(a) *Definitions.* As used in this clause—

“Covered article” means any hardware, software, or service that—

- (1) Is developed or provided by a covered entity;
- (2) Includes any hardware, software, or service developed or provided in whole or in part by a covered entity; or
- (3) Contains components using any hardware or software developed in whole or in part by a covered entity.

“Covered entity” means—

- (1) Kaspersky Lab;
- (2) Any successor entity to Kaspersky Lab;
- (3) Any entity that controls, is controlled by, or is under common control with Kaspersky Lab; or
- (4) Any entity of which Kaspersky Lab has a majority ownership.

(b) *Prohibition.* Section 1634 of Division A of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. 115-91) prohibits Government use of any covered article. The Contractor is prohibited from—

- (1) Providing any covered article that the Government will use on or after October 1, 2018; and
- (2) Using any covered article on or after October 1, 2018, in the development of data or deliverables first produced in the performance of the contract.

(c) *Reporting requirement.*

(1) In the event the Contractor identifies a covered article provided to the Government during contract performance, or the Contractor is notified of such by a subcontractor at any tier or any other source, the Contractor shall report, in writing, to the Contracting Officer or, in the case of the Department of Defense, to the website at <https://dibnet.dod.mil>. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at <https://dibnet.dod.mil>.

(2) The Contractor shall report the following information pursuant to paragraph (c)(1) of this clause:

(i) Within 1 business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; brand; model number (Original Equipment Manufacturer (OEM) number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the report pursuant to paragraph (c)(1) of this clause: any further available information about mitigation actions undertaken or

recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of a covered article, any reasons that led to the use or submission of the covered article, and any additional efforts that will be incorporated to prevent future use or submission of covered articles.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts, including subcontracts for the acquisition of commercial items.

12. Section 5.75 Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment

This is a new section added to the contract to provide rules on the Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment.

**SECTION 5.75 PROHIBITION ON CONTRACTING FOR CERTAIN
TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT
(AUG 2019) (FAR 52.204-25).**

(a) *Definitions.* As used in this clause—

“Covered foreign country” means The People’s Republic of China.

“Covered telecommunications equipment or services” means—

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

“Critical technology” means—

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled-

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

“Substantial or essential component” means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) *Prohibition.* Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115-232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in Federal Acquisition Regulation 4.2104.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) *Reporting requirement.* (1) In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at <https://dibnet.dod.mil>. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at <https://dibnet.dod.mil>.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts*. The Contractor shall insert the substance of this clause, including this paragraph (e), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial items.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1

ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term “repeated” in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member’s insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2

HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3

DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as “Participating Plans”).

SECTION 4.4

AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM’s Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier’s and Participating Plans’ performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5

ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6

TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

- (i) the actual aggregate charges for those costs, or
- (ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7

MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBA 1652.244-70).

SECTION 4.8

PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9

SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10

LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11

PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12

TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13

PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals: the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}} \right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:

(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or

(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports \$900 on IRS Form 8963 and pays \$500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$500 HIP Fee, F's Form 8963 reflects that \$300 is attributable to F's FEHBP business.

Also in 2015, G reports \$950 on IRS Form 8963 and pays \$550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$550 HIP Fee, G's Form 8963 reflects that \$325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $\$300 + \$325 = \$725$, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of \$300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: $(\$300/1-.35)-\$300 = \$162$

Local Plan G HIP Tax Cost: $(\$325/1-.20)-\$325 = \$81$

Sum which is C's allowable HIP Tax Cost for 2015 = \$243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of $300 + 325 = \$725$, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162

Local Plan G HIP Tax Cost for 2016 = 0

Reimbursement attributable to G = adjustment for amounts drawn down by C, if any

Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes \$162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes \$81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of \$325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as \$325 (2016 HIP Fee) divided by $1 - 20\%$ (application of 2017 Local Plan Tax Rate), less \$325.]

Local Plan F HIP Tax Cost for 2017 = 162

Local Plan G HIP Tax Cost for 2017 = 81

Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of $20\% = 81$

Sum = C's allowable HIP Tax Cost for 2017 = $162 + 81 + 81 = \$324$

APPENDIX A

2020

FEP Brochures Text

For a copy of the 2020 FEP brochures, please go to
www.fepblue.org.

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

Blue Cross and Blue Shield Service Benefit Plan

CONTRACT NO. CS 1039

Effective January 1, 2020

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Basic Option: \$292.10 Self, \$656.47 Self Plus One, and \$709.32 Self and Family

Standard Option: \$339.12 Self, \$741.61 Self Plus One, and \$801.16 Self and Family

FEP Blue Focus: \$204.40 Self, \$439.44 Self Plus One, and \$483.37 Self and Family

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

<u>Item</u>	<u>Amount</u>
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2020,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	REDACTED

*The Contractual Expense Limitation for 2020 is **REDACTED** Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the

Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2020 contract year is based on the Overall Performance Score calculated in accordance with the 2019 Appendix F. The Service Charge for the 2021 contract year will be based on the Overall Performance Score calculated in accordance with the 2020 Appendix F.

APPENDIX F

Measures and contributions to performance areas and scores for 2020 Performance and 2021 Service Charge

To be performed in accordance with the 2020 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the 2021 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	1	2.50
	Prenatal Care (Timeliness)	1	2.50
	Comprehensive Diabetes Care HbA1C <8%	1	2.50
	Breast Cancer Screening	2	1.25
	Well Child Visits in the First 15 Months of Life (6 visits)	2	1.25
	Flu Vaccinations for Adults (18-64)	2	1.25
	Cervical Cancer Screening	2	1.25

	Asthma Medication Ratio	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up after Discharge from Emergency Department for Mental Illness (30 day)	2	1.25
	Follow-up after Discharge from Emergency Department for Alcohol or other Drug Dependence (30 Day)	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	2	1.25
	Colorectal Cancer Screening	2	1.25
Customer Service	Getting Care Quickly	3	1.00
	Getting Needed Care	3	1.00
	Claims Processing	3	1.00
	Overall Health Plan Rating	3	1.00
	Coordination of Care	3	1.00
	Overall Personal Doctor Rating	3	1.00
Resource Use	Emergency Department Utilization	2	1.25
	Use of Imaging Studies for Low Back Pain	1	2.50

Exhibit J

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

*Standard Contract
Amendment*

For

Fee-For-Service Carriers

2021

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2021A
EFFECTIVE: January 1, 2021

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G. Street, NW
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

FOR THE GOVERNMENT

William A. Breskin

Sylvia V. Pulley

Name of Person Authorized to
Execute Contract (Type or print)

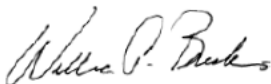
(Type or print)

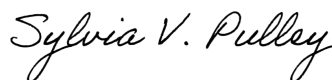
Senior Vice President, Government
Programs

Contracting Officer

Title

Title





Signature

Signature

12/24/2020

Date Signed

12/28/2020

Date Signed

1. Section 1.7 Statistics and Special Studies

We added part (e) to this section to ensure Carriers notify OPM should they receive a Third-Party request about FEHB program data that is not related to the administration of the contract.

SECTION 1.7 STATISTICS AND SPECIAL STUDIES (JAN 2021)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Health Insurance Specialist (Contracts) immediately upon a change in the name or address of the Carrier's contracting official(s).

(e) The Carrier shall notify the OPM Health Insurance Specialist within 3 business days from the date of request if a third party requests FEHB program data for any purpose not related to administration of the contract.

2. Section 1.9 Plan Performance – Experience-Rated FFS Contract

We clarified the language for the Contract Quality Assurance metrics. The metrics themselves have not been modified.

SECTION 1.9 PLAN PERFORMANCE—EXPERIENCE-RATED FFS CONTRACTS (2021)

* * * * *

(d) Accreditation. To demonstrate its commitment to providing quality health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined by OPM. The Carrier shall submit accreditation changes and updates to its OPM Health Insurance Specialist (Contracts).

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Consumer Assessments of Healthcare Providers and Systems (CAHPS) 5.0 Survey to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality over the contract period. The Carrier shall meet the required standards provided in this section. No later than July 1 of the

subsequent year, the Carrier shall submit to OPM an annual report of metrics on each specification provided in this section, using data for the contract period.

(1) Claims Processing Accuracy

SPECIFICATION: the number of FEHB claims processed accurately divided by the total number of FEHB claims processed.

REQUIRED STANDARD: The Carrier shall accurately process at least 95 percent of FEHB claims.

(2) Claims Coding Accuracy

SPECIFICATION: the number of FEHB claims coded accurately divided by the total number of FEHB claims.

REQUIRED STANDARD: The Carrier shall accurately code at least 98 percent of FEHB claims.

(3) Recovery of Erroneous Payments

SPECIFICATION: the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier shall average no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) Claims Timeliness

SPECIFICATION: the number of FEHB claims adjudicated (paid, denied, or a request for further information is sent out) within 30 working days from the date the Carrier received the claim, divided by the total number of FEHB claims received.

REQUIRED STANDARD: The Carrier shall adjudicate at least 95 percent of claims within 30 working days.

(5) Processing ID cards on change of plan or option –

SPECIFICATION: the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier shall issue all ID cards within 15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier shall issue ID cards resulting from an open season election within 15 calendar days or by December 15, whichever is later.

(6) Member Inquiries

SPECIFICATION: the number of written inquiries responded to within 15 working days divided by the total number of written inquiries received.

REQUIRED STANDARD: The Carrier shall respond to at least 90 percent of inquiries within 15 working days.

(7) Written Inquiries Accuracy

SPECIFICATION: the number of FEHB written inquiries answered accurately divided by the total number of FEHB written inquiries received.

REQUIRED STANDARD: the Carrier shall accurately answer at least 97 percent of FEHB written inquiries.

(8) Telephone Inquiries Accuracy

SPECIFICATION: the number of FEHB telephone inquiries answered accurately divided by the total number of FEHB telephone inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB telephone inquiries.

(9) Internet Inquiries Accuracy

SPECIFICATION: the number of FEHB Internet inquiries answered accurately divided by the total number of FEHB Internet inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB Internet inquiries.

(10) Telephone Access - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness

SPECIFICATION: the percentage of calls answered by a live voice (during operating hours).

REQUIRED STANDARD: The Carrier shall answer 80% of telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) Telephone Blockage Rate

SPECIFICATION: the number of calls receiving a busy signal when calling the Carrier, divided by the total number of calls received.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls receive a busy signal.

(iii) Telephone Abandonment Rate

SPECIFICATION: the number of calls attempted but not connected to a live voice, divided by the total number of calls attempted.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls are abandoned before connection to a live voice.

(iv) Initial Call Resolution

SPECIFICATION: the number of initial calls that result in a resolution of the issue, divided by the total number of initial calls for an issue.

REQUIRED STANDARD: The Carrier shall resolve the issue during the initial call at least 80 percent of the time.

(11) Responsiveness to FEHB Member Requests for Reconsideration

SPECIFICATION: the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim, divided by the total number of requests for reconsideration of disputed claims received.

REQUIRED STANDARD: The Carrier shall respond to 100 percent of written FEHB disputed claim requests within 30 days after receipt by the Carrier.

* * * * *

3. Section 1.26 Standards for Arrangements with Pharmacy Benefit Managers

We amended this section to provide clarity on existing guidance, add terminology and definitions on “Pass-through transparent pricing,” and to remove redundancies. We added performance standards on specialty pharmacy shipping. We added a requirement that PBMs

and certain PBM subcontractors must establish a system for detecting and eliminating Fraud Waste and Abuse.

SECTION 1.26 STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2021)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family members effective on or after January 1, 2022. Notwithstanding the foregoing, the revisions to Section 1.26 shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2024. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.26.

If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.26 shall be deemed to be references to the Underwriter.

(a) Definitions. Under this section

- (1) "Expedited request" means a request initiated by the Prescriber, member, or member's representative when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient's life, health, or ability to regain maximum function.
- (2) "Licensed pharmacist" means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction's laws and regulations.
- (3) "Manufacturer payment" means any and all compensation, financial benefits, or remuneration the PBM or any Third Party receives from a pharmaceutical manufacturer for any dispensing or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, patient assistance and any fees received for sales of utilization data to a pharmaceutical manufacturer.
- (4) "Network pharmacy," means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.
- (5) "Pass-Through Transparent Pricing" means drug pricing in which the Carrier receives the full value of all discounts, rebates, credits or other financial guarantees or adjustments including any true up or reconciliation.
- (6) "Pharmacy Benefit Manager" or "PBM" means the combination of
 - (i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs; and

- (ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).
- (7) “Prescriber” means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.
- (8) “Third Party” means any consultant, partner, administrator, intermediary or other entity outside the scope of the relationships between or among the PBM and the FEHB enrollee, Carrier, and/or OPM. It does not include wholesalers, distributors, or pharmacies.
- (9) “Total Product Revenue” means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail Networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM’s entire client base, for the reporting period.
- (b) Transparency Standards
 - (1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.
 - (2) The PBM shall agree to provide Pass-Through Transparent Pricing as defined above for the following categories:
 - (i) Retail Pharmacies: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.
 - (ii) Mail Order or Specialty Pharmacies not owned or affiliated with the PBM: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.
 - (iii) Mail Order or Specialty Pharmacies owned or affiliated with the PBM: The PBM shall charge the Carrier the cost of the drugs based on the pharmacy’s actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks or set pricing including, but not limited to, Average Acquisition Cost (AAC), Maximum Allowable Charge (MAC), Average Wholesale Price (AWP), and Wholesale Acquisition Cost (WAC).
 - (iv) The PBM must commit to minimum annual aggregate pharmacy claim discount guarantees, based on Average Wholesale Price (AWP) or other recognized industry benchmark, and maximum annual aggregate dispensing fee guarantees. PBM must reconcile Carrier claim costs to these guarantees no less frequently than annually. PBM must pay to the Carrier any shortfall in meeting these pricing guarantees, with the Carrier receiving any payment for under-performance of the pricing guarantees to credit its’ FEHB Program reserves.
 - (3) The PBM or any other Third Party that negotiates or collects Manufacturer Payments allocable to the Carrier agrees to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocable to the Carrier.
 - (4) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.
 - (5) All of the PBM’s fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM.
 - (6) The PBM, or any Third Party that negotiates or collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer

Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a specialty and/or a mail order pharmacy, and its retail Network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75 percent of the total cost to the Carrier, whichever is the greater number:

- (i) the dollar amount of Total Product Revenue;
 - (ii) the dollar amount of total drug expenditures for the Plan;
 - (iii) the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;
 - (iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.
 - (v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as “formulary” or “base” rebates or payments pursuant to the PBM’s agreements with pharmaceutical manufacturers;
 - (vi) the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.
- (7) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier, including but not limited to, a reasonable sample of retail pharmacy remittance advices, as selected by the Carrier.
- (8) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. At OPM’s request, the Carrier must obtain from the PBM any reasonable information or reports and provide it to OPM. A PBM providing information to a Carrier under this subsection may mark that information as confidential commercial information. The Carrier, in its contract with the PBM shall effectuate the PBM’s consent to the disclosure of this information to OPM. OPM shall handle the information in accordance with 5 CFR Part 294.
- (9) The Carrier will require that its PBM:
- (i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;
 - (ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and
 - (iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.
- (10) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General

(OPM OIG). The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

- (i) All PBM contracts with Participating Pharmacies, including invoices, receipts and credits;
- (ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;
- (iii) All PBM contracts with Third Parties purchasing or using claims data;
- (iv) All PBM transmittals in connection with sales of claims data to Third Parties or other entities;
- (iv) All PBM Maximum Allowable Cost (MAC) price lists;
- (v) All PBM records relating to patient assistance maximizer programs, optimizer programs, or similar arrangements with Third Parties; and
- (vi) All PBM records pertaining to arrangements with Third Parties, including Group Purchasing Organizations (GPOs).

(c) Integrity Standards

- (1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association, for their employed pharmacists.
- (2) The Carrier will require that its PBM be licensed as required by the appropriate jurisdiction's laws and regulations.
- (3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.
- (4) The PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.
- (5) A PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.
- (6) A PBM, or Carrier, shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:
 - (i) The cost of a prescription medication to the member; or
 - (ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, customer service, claims processing, and other applicable standards set for Carriers at Section 1.9(f). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to

OPM information demonstrating the problems associated with making the requested revisions in full.

- (1) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to Network pharmacies.
- (2) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, Network pharmacies.
- (3) Licensing. The PBM verifies the appropriate licensing of its Network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.
- (4) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.
- (5) Mail service pharmacy turnaround time – The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.
- (6) Specialty pharmacy shipment stability. The Carrier or PBM's specialty pharmacy must have policies and procedures in place to promote effective shipping practices and monitor cold chain packaging. Specific areas to be addressed include achievement of internal and external metrics and the identification and appropriate use of best practices.
- (7) Quality of Drug Therapy. The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Alternative Drug Options

The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

- (1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.
- (2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other office staff member as authorized by the Prescriber.
- (3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescriber's office and the basis for his or her authority.
- (4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.
- (5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.

- (6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.
- (f) Utilization Management Timeframe – The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.
 - (1) For Expedited requests, the PBM must review and respond within 24 hours.
 - (2) For other, non-expedited requests, the PBM must review and respond within 72 hours.
- (g) Patient Safety Standard - The Carrier will require that its PBM establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:
 - (i) A system for identifying and communicating drug and consumer safety issues at point-of-service;
 - (ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.
 - (iii) A system/process for error reporting; and
 - (iv) A system/process for identifying/managing risk
- (h) Safety and Accessibility for Consumers - The Carrier will require that its PBM meets the following standards related to pharmacy Network management and consumer access to medications.
 - (1) The Carrier will require that its PBM define the scope of its services with respect to:
 - (i) The distribution channels offered (e.g. pharmacy Network, mail order pharmacies, or specialty pharmacies);
 - (ii) The types of pharmacy services offered within each distribution channel; and
 - (iii) The geographic area served by each distribution channel.
 - (2) The Carrier will require that for each distribution channel provided by its PBM, the PBM:
 - (i) Establishes criteria and measures actual performance in comparison to those criteria; and
 - (ii) Makes improvements where necessary to maintain the Network and meet contractual requirements.
 - (3) The Carrier will require that its PBM establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:
 - (i) Quality and safety of drug distribution; and
 - (ii) Quality of service
- (i) Fraud, Waste, and Abuse
 - (1) The PBM must establish fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
 - (i) A system designed to detect and eliminate FWA
 - (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
 - (iii) A system/process for FWA reporting; and
 - (iv) A system/process for identifying/managing risk
 - (2) Any Third Party or entity providing services or supplies related to the administration of payments or benefits must certify to the PBM that it has established fraud, waste and

abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:

- (i) A system designed to detect and eliminate FWA;
 - (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
 - (iii) A system/process for FWA reporting; and
 - (iv) A system/process for identifying/managing risk.
- (j) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

4. Section 1.32 Carrier Personnel Access Determination Requirements

This section was amended to update the website address for Memorandum M-05-24.

SECTION 1.32 CARRIER PERSONNEL ACCESS DETERMINATION REQUIREMENTS (JAN 2021)

(a) Carrier personnel who receive a user identification and password to access OPM's LOC System shall comply with the U.S. Office of Management and Budget (OMB) Memorandum M-05-24, referenced in paragraph (a) of FAR 52.204-9, Personal Identity Verification of Contractor Personnel, which is available on-line at <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2005/m05-24.pdf>

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5. New: Section 1.37 Procedures for Information Security Incident and Data Breach Reporting

We added a new section to provide the Carrier contractual guidance for reporting an Information Security Incident and a Data Breach.

SECTION 1.37 PROCEDURES FOR INFORMATION SECURITY INCIDENT AND DATA BREACH REPORTING (JAN 2021)

- (a) The specific terms listed below are defined as stated for purposes of this Section.
 - (1) Incident is defined by 44 U.S.C. § 3552(b)(2) and applicable OMB guidance.
 - (2) Breach is defined in HHS regulations 45 CFR Part 164 Subpart D.
 - (3) Compromise is defined in the current revisions of the glossary of NIST SP 800-32.
- (b) A Carrier must report to OPM incidents and breaches where the confidentiality, integrity, or availability of FEHB member protected health information (PHI) is compromised or if a Carrier notifies law enforcement of an incident or breach that: (1) compromises its systems that contain or process FEHB Program data or (2) compromises its systems operating in the

same general information technology control environment as the information systems that process FEHB Program data.

- (c) The Carrier must report to OPM before any other external notifications are made (excluding notification to necessary parties for incident response), and in no case later than 24 hours after its incident response team determines the confidentiality, integrity, or availability of FEHB member PHI is compromised, or it has notified law enforcement of an incident or breach that meets the requirements stated in paragraph (b) of this Section.
- (d) The Carrier must submit reports to OPM via email to Cybersolutions@opm.gov or via phone to (844) 377-6109.
 - (1) Any data shared with OPM that relates to an incident or breach must be transmitted in a secure manner.
 - (2) The report should include the following:
 - i. A brief description of the nature of the incident or breach.
 - ii. An estimate of the number of affected FEHB members, if feasible.
 - iii. A brief description of the remedial steps that the Carrier has already taken and those they plan to take.
 - (3) The Carrier is responsible for providing additional detailed information as soon as it becomes available.
- (e) For a breach of PHI, the notice to FEHB enrollees will comport with 45 CFR § 164.404 for breaches as defined in this Section or OPM guidance and must be coordinated with OPM before any communication with FEHB enrollees. All other notices must also be coordinated with OPM and the Carrier must follow OPM guidance to the extent practicable.
- (f) In case of a subcontractor breach or incident the following applies.
 - (1) A subcontractor breach or incident must be reported to OPM by the Carrier no later than the calendar day following notice to the Carrier.
 - (2) Either the Carrier or its subcontractor may provide a notice of the breach to FEHB enrollees.
 - (3) If the subcontractor provides the notice, it must be in a form that allows the enrollee to easily identify the Carrier and FEHB plan. If specific identification is not practical under the circumstances, Carrier and FEHB plan identification shall be otherwise accomplished in a manner agreed upon with OPM.
 - (4) The Contracting Officer may direct the Carrier to issue a separate notice in order to avoid enrollee confusion.

6. Section 2.3 Payment of Benefits and Provision of Services and Supplies

We added this language to provide guidance to Carriers for erroneous payment recoveries in cases of Fraud and Abuse.

SECTION 2.3 PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2021)

* * * * *

(g) Erroneous Payments It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program. If the Carrier determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. In the case of fraud or abuse, the Carrier must coordinate with OPM OIG as required by Section 1.9 and OPM's Fraud, Waste and Abuse guidance. The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. §1631.201-70(h) regardless of any time period limitations in the written agreement with the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

- (1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;
- (2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;
- (3) (i) The Carrier may off-set future Benefits payable to the Member or to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.
(ii) Notwithstanding section 2.3(g)(3)(i), a Carrier may set up benefit off-sets to a provider less than 120 days after the first notice as long as the Carrier electing this option continues to comply with any remaining applicable steps enumerated in this subsection 2.3(g) as part of the Carrier's effort to recover erroneous benefit payments.
- (4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; provided, however, that the Carrier may not commence an overpayment recovery lawsuit later than December 31 of the third year after the year in which the overpayment was discovered by the Carrier (except in cases where the False Claims Act, 31 U.S.C § 3729, or another federal limitations period applies);
- (5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;
- (6) Additional prompt and diligent effort is required for significant claim overpayments that exceed \$10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and Third Party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts.
- (7) Suspend recovery efforts for a debt which is based upon a retroactive disenrollment that

- has been appealed under 5 C.F.R. § 890.104 or a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;
- (8) (i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it made a prompt and diligent effort to recover erroneous payments as described above.
 - (ii) Notwithstanding (g)(8)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii);
 - (9) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.
 - (10) If OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the Member, from the Member or, if to the provider, from the provider as specified in (g)(1) through (9).
 - (11) At the request of OPM, the Carrier shall provide evidence that it has taken the steps enumerated above in this subsection to promptly recover erroneous payments, including but not limited to overpayments related to Medicare coordination of benefits. OPM will review the Carrier's claims payments and procedures to validate the Carrier's prompt and diligent effort. The Contracting Officer may require the Carrier to establish and submit to the Contracting Officer a written corrective action plan.
 - (12) In compliance with the provisions of the Contract Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment.
- (h) Erroneous payment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.
- (i) All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.
- (j) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

7. FAR Changes

We have updated the following sections so that they are consistent with the Federal Acquisition Regulation (FAR).

SECTION 5.1

DEFINITIONS (JUN 2020) (FAR 52.202-1)

When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as the definition in FAR 2.101 in effect at the time the solicitation was issued, unless—

- (a) The solicitation, or amended solicitation, provides a different definition;

- (b) The contracting parties agree to a different definition;
- (c) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning;
- (d) The word or term is defined in FAR Part 31, for use in the cost principles and procedures; or
- (e) The word or term defines an acquisition-related threshold, and if the threshold is adjusted for inflation as set forth in FAR 1.109(a), then the changed threshold applies throughout the remaining term of the contract, unless there is a subsequent threshold adjustment; see FAR 1.109(d).

SECTION 5.5

ANTI-KICKBACK PROCEDURES (JUN 2020) (FAR 52.203-7)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor," as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) 41 U.S.C. chapter 87, Kickbacks, prohibits any person from --

- (1) Providing or attempting to provide or offering to provide any kickback;
- (2) Soliciting, accepting, or attempting to accept any kickback; or
- (3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Attorney General.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold, from sums owed a subcontractor under the prime contract, the amount of the kickback. The Contracting Officer may order that monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including this paragraph (c)(5) but excepting paragraph (c)(1) of this clause, in all subcontracts under this contract that exceed the threshold specified in Federal Acquisition Regulation 3.502-2(i) on the date of subcontract award.

SECTION 5.7

AUDIT AND RECORDS-NEGOTIATION (JUN 2020) (FAR 52.215-2)

(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

(b) *Examination of costs.* If this is a cost-reimbursement, incentive, time-and-materials, labor-hour, or price redeterminable contract, or any combination of these, the Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the Contractor's plants, or parts of them, engaged in performing the contract.

(c) *Certified cost or pricing data.* If the Contractor has been required to submit certified cost or pricing data in connection with any pricing action relating to this contract, the Contracting Officer, or an authorized representative of the Contracting Officer, in order to evaluate the accuracy, completeness, and currency of the certified cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to--

- (1) The proposal for the contract, subcontract, or modification;
- (2) The discussions conducted on the proposal(s), including those related to negotiating;
- (3) Pricing of the contract, subcontract, or modification; or
- (4) Performance of the contract, subcontract or modification.

(d) *Comptroller General* -- (1) The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records involving transactions related to this contract or a subcontract hereunder and to interview any current employee regarding such transactions.

(1) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e) *Reports*. If the Contractor is required to furnish cost, funding, or performance reports, the Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating--

(1) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports and (2) The data reported.

(f) *Availability*. The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition--(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 3 years after any resulting final termination settlement; and (2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

(g) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (g), in all subcontracts under this contract that exceed the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, and--

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;

(2) For which certified cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (e) of this clause.

The clause may be altered only as necessary to identify properly the contracting parties and the Contracting Officer under the Government prime contract.

SECTION 5.10

SUBCONTRACTOR CERTIFIED COST OR PRICING DATA (JUN 2020) (FAR 52.215-12)

(a) Before awarding any subcontract expected to exceed the threshold for submission of certified cost or pricing data in Federal Acquisition Regulation (FAR) 15.403-4(a)(1), on the date of agreement on price or the date of award, whichever is later; or before pricing any subcontract modification involving a pricing adjustment expected to exceed the threshold for submission of certified cost or pricing data in FAR 15.403-4(a)(1), the Contractor shall require the subcontractor to submit certified cost or pricing data (actually or by specific identification in writing), in accordance with FAR 15.408, Table 15-2 (to include any information reasonably required to explain the subcontractor's estimating process such as the judgmental factors applied and the mathematical or other methods used in the estimate, including those used in projecting from known data, and the nature and amount of any contingencies included in the price), unless an exception under 15.403-1(b) applies. If the threshold for submission of certified cost or pricing data specified in FAR 15.403-4(a)(1) is adjusted for inflation as set forth in FAR 1.109(a),

then pursuant to FAR 1.109(d) the changed threshold applies throughout the remaining term of the contract, unless there is a subsequent threshold adjustment.

(b) The Contractor shall require the subcontractor to certify in substantially the form prescribed in FAR 15.406-2 that, to the best of its knowledge and belief, the data submitted under paragraph (a) of this clause were accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or subcontract modification.

(c) In each subcontract that, when entered into, exceeds the threshold for submission of certified cost or pricing data in FAR 15.403-4(a)(1), the Contractor shall insert either --

(1) The substance of this clause, including this paragraph (c), if paragraph (a) of this clause requires submission of certified cost or pricing data for the subcontract; or

(2) The substance of the clause at FAR 52.215-13, Subcontractor Certified Cost or Pricing Data - Modifications.

SECTION 5.22

EQUAL OPPORTUNITY FOR VETERANS (JUN 2020) (FAR 52.222-35)

(a) *Definitions.* As used in this clause—

“Active duty wartime or campaign badge veteran,” “Armed Forces service medal veteran,” “disabled veteran,” “protected veteran,” “qualified disabled veteran,” and “recently separated veteran” have the meanings given at Federal Acquisition Regulation (FAR) 22.1301.

(b) *Equal opportunity clause.* The Contractor shall abide by the requirements of the equal opportunity clause at 41 CFR 60-300.5(a), as of March 24, 2014. This clause prohibits discrimination against qualified protected veterans, and requires affirmative action by the Contractor to employ and advance in employment qualified protected veterans.

(c) *Subcontracts.* The Contractor shall insert the terms of this clause in subcontracts valued at or above the threshold specified in FAR 22.1303(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary of Labor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs, to enforce the terms, including action for noncompliance. Such necessary changes in language may be made as shall be appropriate to identify properly the parties and their undertakings.

SECTION 5.23

EQUAL OPPORTUNITY FOR WORKERS WITH DISABILITIES (JUN 2020) (FAR 52.222-36)

(a) *Equal opportunity clause.* The Contractor shall abide by the requirements of the equal opportunity clause at 41 CFR 60-741.5(a), as of March 24, 2014. This clause prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by the Contractor to employ and advance in employment qualified individuals with disabilities.

(b) *Subcontracts.* The Contractor shall include the terms of this clause in every subcontract or purchase order in excess of the threshold specified in Federal Acquisition Regulation (FAR) 22.1408(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary, so that such provisions will be binding upon each

subcontractor or vendor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs of the U.S. Department of Labor, to enforce the terms, including action for noncompliance. Such necessary changes in language may be made as shall be appropriate to identify properly the parties and their undertakings.

SECTION 5.45

LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (JUN 2020) (FAR 52.203-12)

(a) *Definitions.* As used in this clause—

“Agency” means “executive agency” as defined in Federal Acquisition Regulation (FAR) 2.101.

“Covered Federal action” means any of the following actions:

- (1) Awarding any Federal contract.
- (2) Making any Federal grant.
- (3) Making any Federal loan.
- (4) Entering into any cooperative agreement.
- (5) Extending, continuing, renewing, amending, or modifying any Federal contract, grant, loan, or cooperative agreement.

“Indian tribe” and “tribal organization” have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b) and include Alaskan Natives.

“Influencing or attempting to influence” means making, with the intent to influence, any communication to or appearance before an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal action.

“Local government” means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

“Officer or employee of an agency” includes the following individuals who are employed by an agency:

- (1) An individual who is appointed to a position in the Government under Title 5, United States Code, including a position under a temporary appointment.
- (2) A member of the uniformed services, as defined in subsection 101(3), Title 37, United States Code.
- (3) A special Government employee, as defined in section 202, Title 18, United States Code.
- (4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, Title 5, United States Code, appendix 2.

“Person” means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit, or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and are permitted by other Federal law.

“Reasonable compensation” means, with respect to a regularly employed officer or

employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

“Reasonable payment” means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

“Recipient” includes the Contractor and all subcontractors. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and *are* permitted by other Federal law.

“Regularly employed” means, with respect to an officer or employee of a person requesting or receiving a Federal contract, an officer or employee who is employed by such person for at least 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract. An officer or employee who is employed by such person for less than 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

“State” means a State of the United States, the District of Columbia, or an outlying area of the United States, an agency or instrumentality of a State, and multi-State, regional, or interstate entity having governmental duties and powers.

(b) *Prohibition.* 31 U.S.C. 1352 prohibits a recipient of a Federal contract, grant, loan, or cooperative agreement from using appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal actions. In accordance with 31 U.S.C. 1352 the Contractor shall not use appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of this contract the extension, continuation, renewal, amendment, or modification of this contract.

(1) The term *appropriated funds* does not include profit or fee from a covered Federal action.

(2) To the extent the Contractor can demonstrate that the Contractor has sufficient monies, other than Federal appropriated funds, the Government will assume that these other monies were spent for any influencing activities that would be unallowable if paid for with Federal appropriated funds.

(c) *Exceptions.* The prohibition in paragraph (b) of this clause does not apply under the following conditions:

(1) *Agency and legislative liaison by Contractor employees.*

(i) Payment of reasonable compensation made to an officer or employee of the Contractor if the payment is for agency and legislative liaison activities not directly related to this contract. For purposes of this paragraph, providing any information specifically requested by an agency or Congress is permitted at any time.

(ii) Participating with an agency in discussions that are not related to a specific solicitation for any covered Federal action, but that concern—

- (A) The qualities and characteristics (including individual demonstrations) of the person's products or services, conditions or terms of sale, and service capabilities; or
- (B) The application or adaptation of the person's products or services for an agency's use.

- (iii) Providing prior to formal solicitation of any covered Federal action any information not specifically requested but necessary for an agency to make an informed decision about initiation of a covered Federal action;
- (iv) Participating in technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and
- (v) Making capability presentations prior to formal solicitation of any covered Federal action by persons seeking awards from an agency pursuant to the provisions of the Small Business Act, as amended by Pub. L. 95-507, and subsequent amendments.

(2) *Professional and technical services.*

- (i) A payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action, if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action.
- (ii) Any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action. Persons other than officers or employees of a person requesting or receiving a covered Federal action include consultants and trade associations.
- (iii) As used in paragraph (c)(2) of this clause, "professional and technical services" are limited to advice and analysis directly applying any professional or technical discipline (for examples, see FAR 3.803(a)(2)(iii)).
- (iv) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation and any other requirements in the actual award documents.

- (3) Only those communications and services expressly authorized by paragraphs (c)(1) and (2) of this clause are permitted.

(d) *Disclosure.*

- (1) If the Contractor did not submit OMB Standard Form LLL, Disclosure of Lobbying Activities, with its offer, but registrants under the Lobbying Disclosure Act of 1995 have subsequently made a lobbying contact on behalf of the Contractor with respect to this contract, the Contractor shall complete and submit OMB Standard Form LLL to provide the name of the lobbying registrants, including the individuals performing the services.
- (2) If the Contractor did submit OMB Standard Form LLL disclosure pursuant to paragraph (d) of the provision at FAR 52.203-11, Certification and Disclosure

Regarding Payments to Influence Certain Federal Transactions, and a change occurs that affects Block 10 of the OMB Standard Form LLL (name and address of lobbying registrant or individuals performing services), the Contractor shall, at the end of the calendar quarter in which the change occurs, submit to the Contracting Officer within 30 days an updated disclosure using OMB Standard Form LLL.

(e) *Penalties.*

(1) Any person who makes an expenditure prohibited under paragraph (b) of this clause or who fails to file or amend the disclosure to be filed or amended by paragraph (d) of this clause shall be subject to civil penalties as provided for by 31 U.S.C. 1352. An imposition of a civil penalty does not prevent the Government from seeking any other remedy that may be applicable.

(2) Contractors may rely without liability on the representation made by their subcontractors in the certification and disclosure form.

(f) *Cost allowability.* Nothing in this clause makes allowable or reasonable any costs which would otherwise be unallowable or *unreasonable*. Conversely, costs made specifically unallowable by the requirements in this clause will not be made allowable under any other provision.

(g) *Subcontracts.*

(1) The Contractor shall obtain a declaration, including the certification and disclosure in paragraphs (c) and (d) of the provision at FAR 52.203–11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions, from each person requesting or receiving a subcontract under this contract that exceeds the threshold specified in FAR 3.808 on the date of subcontract award. The Contractor or subcontractor that awards the subcontract shall retain the declaration.

(2) A copy of each subcontractor disclosure form (but not certifications) shall be forwarded from tier to tier until received by the prime Contractor. The prime Contractor shall, at the end of the calendar quarter in which the disclosure form is submitted by the subcontractor, submit to the Contracting Officer within 30 days a copy of all disclosures. Each subcontractor certification shall be retained in the subcontract file of the awarding Contractor.

(3) The Contractor shall include the substance of this clause, including this paragraph (g), in any subcontract that exceeds the threshold specified in FAR 3.808 on the date of subcontract award.

SECTION 5.47

PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (JUN 2020) (FAR 52.209-6)

(a) Definition. “Commercially available off-the-shelf (COTS)” item, as used in this clause—

(1) Means any item of supply (including construction material) that is—

(i) A commercial item (as defined in paragraph (1) of the definition in Federal Acquisition Regulation (FAR) 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as

agricultural products and petroleum products.

(b) The Government suspends or debar Contractors to protect the Government's interests. Other than a subcontract for a commercially available off-the-shelf item, the Contractor shall not enter into any subcontract, in excess of the threshold specified in FAR 9.405-2(b) on date of subcontract award with a Contractor that is debarred, suspended, or proposed for debarment by any executive agency unless there is a compelling reason to do so.

(c) The Contractor shall require each proposed subcontractor whose subcontract will exceed the threshold specified in FAR 9.405-2(b) on the date of the subcontract award, other than a subcontractor providing a commercially available off-the-shelf item, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(d) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party (other than a subcontractor providing a commercially available off-the-shelf item) that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the System for Award Management (SAM) Exclusions). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being listed with an exclusion in SAM.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its being listed with an exclusion in SAM.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(e) Subcontracts. Unless this is a contract for the acquisition of commercial items, the Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for the identification of the parties), in each subcontract that—

(1) Exceeds the threshold specified in FAR 9.405-2(b) on the date of subcontract award; and

(2) Is not a subcontract for commercially available off-the-shelf items.

SECTION 5.55

EMPLOYMENT REPORTS ON VETERANS (JUN 2020) (FAR 52.222-37)

(a) Definitions. As used in this clause, "active duty wartime or campaign badge veteran," "Armed Forces service medal veteran," "disabled veteran" "protected veteran," and "recently separated veteran," have the meanings given in FAR 22.1301.

(b) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on—

(1) The total number of employees in the contractor's workforce, by job category and hiring location, who are protected veterans (i.e., active duty wartime or campaign badge veterans, Armed Forces service medal veterans, disabled veterans and recently separated veterans);

(2) The total number of new employees hired during the period covered by the report, and of the total, the number of protected veterans (i.e., active duty

wartime or campaign badge veterans, Armed Forces service medal veterans, disabled veterans, and recently separated veterans); and

(3) The maximum number and minimum number of employees of the Contractor or subcontractor at each hiring location during the period covered by the report.

(c) The Contractor shall report the above items by filing the Form VETS-4212, entitled “Federal Contractor Veterans’ Employment Report” (see VETS-4212 Federal Contractor Reporting” and Filing Your VETS-4212 Report” at <http://www.dol.gov/vets/vets4212.htm>)”

(d) The Contractor shall submit VETS-4212 Reports no later than September 30 of each year.

(e) The employment activity report required by paragraphs (b)(2) and (b)(3) of this clause shall reflect total new hires, and maximum and minimum number of employees, during the most recent 12-month period preceding the ending date selected for the report. Contractors may select an ending date—

(1) As of the end of any pay period between July 1 and August 31 of the year the report is due; or

(2) As of December 31, if the Contractor has prior written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(f) The number of veterans reported must be based on data known to the contractor when completing the VETS-4212. The contractor’s knowledge of veterans status may be obtained in a variety of ways, including an invitation to applicants to self-identify (in accordance with 41 CFR 60–300.42), voluntary self-disclosure by employees, or actual knowledge of veteran status by the contractor. This paragraph does not relieve an employer of liability for discrimination under 38 U.S.C. 4212.

(g) The Contractor shall insert the terms of this clause in subcontracts valued at or above the threshold specified in FAR 22.1303(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary of Labor.

SECTION 5.56

AUTHORIZATION AND CONSENT (JUN 2020) (FAR 52.227-1)

(a) The Government authorizes and consents to all use and manufacture, in performing this contract or any subcontract at any tier, of any invention described in and covered by a United States patent—

(1) Embodied in the structure or composition of any article the delivery of which is accepted by the Government under this contract; or

(2) Used in machinery, tools, or methods whose use necessarily results from compliance by the Contractor or a subcontractor with (i) specifications or written provisions forming a part of this contract or (ii) specific written instructions given by the Contracting Officer directing the manner of performance. The entire liability to the Government for infringement of a United States patent shall be determined solely by the provisions of the indemnity clause, if any, included in this contract or any subcontract hereunder (including any lower-tier subcontract), and the Government assumes liability for all other infringement to the extent of the authorization and consent hereinabove granted.

(b) The Contractor shall include the substance of this clause, including this paragraph (b), in all subcontracts that are expected to exceed the simplified acquisition threshold, as

defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award. However, omission of this clause from any subcontract, including those at or below the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award, does not affect this authorization and consent.

SECTION 5.57

NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT (JUN 2020) (FAR 52.227-2)

(a) The Contractor shall report to the Contracting Officer, promptly and in reasonable written detail, each notice or claim of patent or copyright infringement based on the performance of this contract of which the Contractor has knowledge.

(b) In the event of any claim or suit against the Government on account of any alleged patent or copyright infringement arising out of the performance of this contract or out of the use of any supplies furnished or work or services performed under this contract, the Contractor shall furnish to the Government, when requested by the Contracting Officer, all evidence and information in the Contractor's possession pertaining to such claim or suit. Such evidence and information shall be furnished at the expense of the Government except where the Contractor has agreed to indemnify the Government.

(c) The Contractor shall include the substance of this clause, including this paragraph (c), in all subcontracts that are expected to exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award.

SECTION 5.60

SUBCONTRACTS FOR COMMERCIAL ITEMS (OCT 2020) (FAR 52.244-6)

(a) Definitions. As used in this clause —

“Commercial item” and “commercially available off-the-shelf item” have the meanings contained in Federal Acquisition Regulation 2.101.

“Subcontract” includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Jun 2020) (41 U.S.C. 3509), if the subcontract exceeds the threshold specified in FAR 3.1004(a) on the date of subcontract award, and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems

(June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204-21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (Jul 2018) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (Aug 2020) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (OCT 2018) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds \$700,000 (\$1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)

(ix) 52.222-26, Equal Opportunity (Apr 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Jun 2020) (38 U.S.C. 4212(a).

(xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jun 2020) (29 U.S.C. 793).

(xii) 52.222-37, Employment Reports on Veterans (Jun 2020) (38 U.S.C. 4212).

(xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xiv)(A) 52.222-50, Combating Trafficking in Persons (Oct 2020) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xv) 52.222-55, Minimum Wages under Executive Order 13658 (Dec 2015), if flow down is required in accordance with paragraph (k) of FAR clause [52.222-55](#).

(xvi) [52.222-62](#), Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flow down is required in accordance with paragraph (m) of FAR clause [52.222-62](#).

(xvii)(A) [52.224-3](#), Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of [52.224-3](#), if flow down is required in accordance with [52.224-3](#)(f) and the agency specifies that only its agency-provided training is acceptable).

(xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xvix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

SECTION 5.64

CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (JUN 2020) (FAR 52.203–13).

(a) *Definitions.* As used in this clause--

Agent means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization.

Full cooperation--(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;

(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require--

(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or

(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and

(3) Does not restrict a Contractor from--

(i) Conducting an internal investigation; or

(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

“Principal” means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a division, or business segment; and similar positions).

“Subcontract” means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

“Subcontractor” means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.

“United States” means the 50 States, the District of Columbia, and outlying areas.

(b) *Code of business ethics and conduct.*

(1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall—

(i) Have a written code of business ethics and conduct; and

(ii) Make a copy of the code available to each employee engaged in performance of the contract.

(2) The Contractor shall--

(i) Exercise due diligence to prevent and detect criminal conduct; and

(ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

(3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed--

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or

(B) A violation of the civil False Claims Act (31 U.S.C. 3729- 3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked "confidential" or "proprietary" by the company. To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Government wide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract.

(c) Business ethics awareness and compliance program and internal control system. This paragraph (c) does not apply if the Contractor has represented itself as a small business concern pursuant to the award of this contract or if this contract is for the acquisition of a commercial item as defined at FAR 2.101. The Contractor shall establish the following within 90 days after contract award, unless the Contracting Officer establishes a longer time period:

(1) An ongoing business ethics awareness and compliance program.

(i) This program shall include reasonable steps to communicate periodically and in a practical manner the Contractor's standards and procedures and other aspects of the Contractor's business ethics awareness and compliance program and internal control system, by conducting effective training programs and otherwise disseminating information appropriate to an individual's respective roles and responsibilities.

(ii) The training conducted under this program shall be provided to the Contractor's principals and employees, and as appropriate, the Contractor's agents and subcontractors.

(2) An internal control system.

(i) The Contractor's internal control system shall--

(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and

(B) Ensure corrective measures are promptly instituted and carried out.

(ii) At a minimum, the Contractor's internal control system shall provide for the following:

(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.

(B) Reasonable efforts not to include an individual as a principal, whom due diligence would have exposed as having engaged in conduct that is in conflict with the Contractor's code of business ethics and conduct.

(C) Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and

compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process.

(D) An internal reporting mechanism, such as a hotline, which allows for anonymity or confidentiality, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(E) Disciplinary action for improper conduct or for failing to take reasonable steps to prevent or detect improper conduct.

(F) Timely disclosure, in writing, to the agency OIG, with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of any Government contract performed by the Contractor or a subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 U.S.C. or a violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(1) If a violation relates to more than one Government contract, the Contractor may make the disclosure to the agency OIG and Contracting Officer responsible for the largest dollar value contract impacted by the violation.

(2) If the violation relates to an order against a Government wide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract, and the respective agencies' contracting officers.

(3) The disclosure requirement for an individual contract continues until at least 3 years after final payment on the contract.

(4) The Government will safeguard such disclosures in accordance with paragraph (b)(3)(ii) of this clause.

(G) Full cooperation with any Government agencies responsible for audits, investigations, or corrective actions.

- (d) Subcontracts. (1) The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts that exceed the threshold specified in FAR 3.1004(a) on the date of subcontract award and a performance period of more than 120 days.

(2) In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

SECTION 5.69

ENCOURAGING CONTRACTOR POLICIES TO BAN TEXT MESSAGING WHILE DRIVING (JUN 2020) (FAR 52.223-18)

(a) Definitions. As used in this clause—
“Driving”–

(1) Means operating a motor vehicle on an active roadway with the motor running, including while temporarily stationary because of traffic, a traffic light, stop sign, or

otherwise.

(2) Does not include operating a motor vehicle with or without the motor running when one has pulled over to the side of, or off, an active roadway and has halted in a location where one can safely remain stationary.

“Text messaging” means reading from or entering data into any handheld or other electronic device, including for the purpose of short message service texting, e-mailing, instant messaging, obtaining navigational information, or engaging in any other form of electronic data retrieval or electronic data communication. The term does not include glancing at or listening to a navigational device that is secured in a commercially designed holder affixed to the vehicle, provided that the destination and route are programmed into the device either before driving or while stopped in a location off the roadway where it is safe and legal to park.

(b) This clause implements Executive Order 13513, Federal Leadership on Reducing Text Messaging While Driving, dated October 1, 2009.

(c) The Contractor is encouraged to—

(1) Adopt and enforce policies that ban text messaging while driving—

(i) Company-owned or -rented vehicles or Government-owned vehicles; or

(ii) Privately-owned vehicles when on official Government business or

when performing any work for or on behalf of the Government.

(2) Conduct initiatives in a manner commensurate with the size of the business, such as—

(i) Establishment of new rules and programs or re-evaluation of existing programs to prohibit text messaging while driving; and

(ii) Education, awareness, and other outreach to employees about the safety risks associated with texting while driving.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts that exceed the micro-purchase threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award.

SECTION 5.70

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (JUN 2020) (FAR 52.203-17).

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and Federal Acquisition Regulation (FAR) 3.908

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section FAR 3.908.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award.

SECTION 5.71

COMBATING TRAFFICKING IN PERSONS (OCT 2020) (FAR 52.222-50)

(a) Definitions. As used in this clause—

“Agent” means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.

“Coercion” means—

- (1) Threats of serious harm to or physical restraint against any person;
- (2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
- (3) The abuse or threatened abuse of the legal process.

“Commercially available off-the-shelf (COTS) item” means-

- (1) Any item of supply (including construction material) that is-
 - (i) A commercial item (as defined in paragraph (1) of the definition at FAR 2.101);
 - (ii) Sold in substantial quantities in the commercial marketplace; and
 - (iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and
- (2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

“Commercial sex act” means any sex act on account of which anything of value is given to or received by any person.

“Debt bondage” means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

“Employee” means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.

“Forced labor” means knowingly providing or obtaining the labor or services of a person—

- (1) By threats of serious harm to, or physical restraint against, that person or another person;
- (2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or
- (3) By means of the abuse or threatened abuse of law or the legal process.

“Involuntary servitude” includes a condition of servitude induced by means of—

- (1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or
- (2) The abuse or threatened abuse of the legal process.

“Recruitment fees” means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.

- (1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

- (i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;
- (ii) Advertising;
- (iii) Obtaining permanent or temporary labor certification, including any associated fees;
- (iv) Processing applications and petitions;
- (v) Acquiring visas, including any associated fees;
- (vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;
- (vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;
- (viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;
- (ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;
- (x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;
- (xi) Transportation and subsistence costs—
 - (A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and
 - (B) From the airport or disembarkation point to the worksite;
- (xii) Security deposits, bonds, and insurance; and
- (xiii) Equipment charges.
- (2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—

- (i) Paid in property or money;
- (ii) Deducted from wages;
- (iii) Paid back in wage or benefit concessions;
- (iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or V-54 (FFS-2020)
- (v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—
 - (A) Agents;
 - (B) Labor brokers;
 - (C) Recruiters;
 - (D) Staffing firms (including private employment and placement firms);
 - (E) Subsidiaries/affiliates of the employer;
 - (F) Any agent or employee of such entities; and
 - (G) Subcontractors at all tiers.

“Severe forms of trafficking in persons” means—

- (1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
- (2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

“Sex trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;

(2) Procure commercial sex acts during the period of performance of the contract; or

(3) Use forced labor in the performance of the contract.

(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee's identity or immigration documents, such as passports or drivers' licenses, regardless of issuing authority;

(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant cost to be charged to the employee, and, if applicable, the hazardous nature of the work;

(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;

(6) Charge employees or potential employees recruitment fees;

(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-

(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or

(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that

(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-

(A) Legally permitted to remain in the country of employment and who chooses to do so; or

(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;

(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.

(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or

(9) If required by law or contract, fail to provide an employment contract, recruitment

agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) Notification.

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i) Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud) ; and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) Remedies. In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) Mitigating and aggravating factors. When determining remedies, the Contracting Officer may consider the following:

(1) Mitigating factors. The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has

taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.

(2) Aggravating factors. The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.

(g) Full cooperation.

(1) The Contractor shall, at a minimum-

(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;

(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;

(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and

(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.

(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-

(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;

(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or

(iii) Restrict the Contractor from-

(A) Conducting an internal investigation; or

(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

(h) Compliance plan.

(1) This paragraph (h) applies to any portion of the contract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds \$550,000.

(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-

(i) To the size and complexity of the contract; and

(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.

(3) Minimum requirements. The compliance plan must include, at a minimum, the following:

(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can be found at the website for the Department of State's Office to Monitor and Combat

Trafficking in Persons at <http://www.state.gov/j/tip/>.

(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888- FREE and its email address at help@befree.org.

(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employee or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.

(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.

(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.

(4) Posting.

(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.

(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.

(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-

(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and

(ii) After having conducted due diligence, either-

(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or

(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.

(i) Subcontracts.

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds \$550,000.

(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

SECTION 5.75

PROHIBITION ON CONTRACTING FOR CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT (AUG 2020) (FAR 52.204-25).

i. *Definitions.* As used in this clause—

“Backhaul” means intermediate links between the core network, or backbone network, and the small subnetworks at the edge of the network (e.g., connecting cell phones/towers to the core telephone network). Backhaul can be wireless (e.g., microwave) or wired (e.g., fiber optic, coaxial cable, Ethernet).

“Covered foreign country” means The People’s Republic of China. “Covered telecommunications equipment or services” means—

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

“Critical technology” means—

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled-

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

“Interconnection arrangements” means arrangements governing the physical connection of two or more networks to allow the use of another’s network to hand off traffic where it is ultimately delivered (e.g., connection of a customer of telephone provider A to a customer of telephone company B) or sharing data and other information resources.

“Reasonable inquiry” means an inquiry designed to uncover any information in the

entity's possession about the identity of the producer or provider of covered telecommunications equipment or services used by the entity that excludes the need to include an internal or third-party audit.

"Roaming" means cellular communications services (e.g., voice, video, data) received from a visited network when unable to connect to the facilities of the home network either because signal coverage is too weak or because traffic is too high.

"Substantial or essential component" means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) Prohibition. (1) Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104.

(2) Section 889(a)(1)(B) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2020, from entering into a contract, or extending or renewing a contract, with an entity that uses any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104. This prohibition applies to the use of covered telecommunications equipment or services, regardless of whether that use is in performance of work under a Federal contract.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) Reporting requirement. (1) In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at <https://dibnet.dod.mil>. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at

<https://dibnet.dod.mil>.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts*. The Contractor shall insert the substance of this clause, including this paragraph (e) and excluding (b)(2), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial items.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1

ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance - Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider Directories will include language advising subscribers to contact their providers directly obtain information about the providers, including but not limited to board certifications, languages spoken, availability of

interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies.

Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a

prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term “repeated” in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan,

shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2

HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3

DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4

AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that

were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5 ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6 TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

- (i) the actual aggregate charges for those costs, or
- (ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7 MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

- 1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or

2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBA 1652.244-70).

SECTION 4.8

PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9

SMALL BUSINESS SUBCONTRACTING PLAN (JUN 2020) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10

LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11

PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12

TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13

PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR
REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE
(JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}} \right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:

- (a) the rate specified at 26 USC §11 (b) (1) (D),
- (b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
- (c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports \$900 on IRS Form 8963 and pays \$500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$500 HIP Fee, F's Form 8963 reflects that \$300 is attributable to F's FEHBP business.

Also in 2015, G reports \$950 on IRS Form 8963 and pays \$550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$550 HIP Fee, G's Form 8963 reflects that \$325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $\$300 + \$325 = \$725$, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of \$300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: $(\$300/1-.35)-\$300 = \$162$

Local Plan G HIP Tax Cost: $(\$325/1-.20)-\$325 = \$81$

Sum which is C's allowable HIP Tax Cost for 2015 = \$243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of $300 + 325 = \$725$, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162

Local Plan G HIP Tax Cost for 2016 = 0

Reimbursement attributable to G = adjustment for amounts drawn down by C, if any

Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes \$162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes \$81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of \$325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as \$325 (2016 HIP Fee) divided by $1 - 20\%$ (application of 2017 Local Plan Tax Rate), less \$325.]

Local Plan F HIP Tax Cost for 2017 = 162

Local Plan G HIP Tax Cost for 2017 = 81

Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of $20\% = 81$

Sum = C's allowable HIP Tax Cost for 2017 = $162 + 81 + 81 = \$324$

APPENDIX A

ATTACH

2021 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

(Blue Cross and Blue Shield Association)

CONTRACT NO. CS 1039

Effective January 1, 2021


(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:


Basic Option: \$302.33 Self, \$679.45 Self Plus One, and \$734.15 Family

Standard Option: \$350.99 Self, \$767.57 Self Plus One, and \$829.20 Family

FEP Blue Focus: \$204.40 Self, \$439.44 Self Plus One, and \$483.37 Family

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

<u>Item</u>	<u>Amount</u>
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2021,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	

*The Contractual Expense Limitation for 2021 is  Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2021 contract year is based on the Overall Performance Score calculated in accordance with the 2020 Appendix F. The Service Charge for the 2022 contract year will be based on the Overall Performance Score calculated in accordance with the 2021 Appendix F.

APPENDIX E
SMALL BUSINESS SUBCONTRACTING PLAN (JUN 2020)

(a) This clause does not apply to small business concerns.

(b) *Definitions.* As used in this clause—

“Alaska Native Corporation (ANC)” means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C.

1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

“Commercial item” means a product or service that satisfies the definition of commercial item in Federal Acquisition Regulation (FAR) 2.101.

“Commercial plan” means a subcontracting plan (including goals) that covers the offeror’s fiscal year and that applies to the entire production of commercial items sold by either the entire company or a portion thereof (e.g., division, plant, or product line).

“Indian tribe” means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

“Individual subcontracting plan” means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror’s planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

“Master subcontracting plan” means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

“Reduced payment” means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

“Subcontract” means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

“Total contract dollars” means the final anticipated dollar value, including the dollar value of all options. “Untimely payment” means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c) (1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting

with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

(2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if—

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The offeror's subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with [43 U.S.C. 1626](#)—

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the

prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns (including ANC and Indian tribes); and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns.

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.*, existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business

trade associations). A firm may rely on the information contained in SAM as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM as its source list does not relieve a firm of its responsibilities (*e.g.*, outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

- (i) Small business concerns (including ANC and Indian tribes);
- (ii) Veteran-owned small business concerns;
- (iii) Service-disabled veteran-owned small business concerns;
- (iv) HUBZone small business concerns;
- (v) Small disadvantaged business concerns; and
- (vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

- (i) Cooperate in any studies or surveys as may be required;
- (ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;
- (iii) After November 30, 2017, include subcontracting data for each order when reporting subcontracting achievements for indefinite-delivery, indefinite-quantity contracts with individual subcontracting plans where the contract is intended for use by multiple agencies;

(iv) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (l) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (l) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in

agency regulations;

(v) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (l) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (l) of this clause

(vi) [RESERVED]; and

(vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own unique entity identifier, and the e-mail address of the subcontractor's official responsible for acknowledging receipt of or rejecting the Standard Forms 294, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.*, SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's

requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if—

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see [52.242-5](#)).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business,

HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran- owned small business, HUBZone small business, small disadvantaged business, or women- owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial items. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial item. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract

modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at [52.212-5](#), Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Items, or when the subcontractor provides a commercial item subject to the clause at [52.244-6](#), Subcontracts for Commercial Items, under a prime contract.

(k) The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled “Utilization Of Small Business Concerns,” or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to [19.702\(a\)\(3\)](#) or [19.301-2\(e\)](#), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(iii) When a subcontracting plan includes indirect costs in the goals, these costs must be included in this report.

(iv) The authority to acknowledge receipt or reject the SF 294 resides—

(A) In the case of the prime Contractor, with the Contracting Officer; and

(B) In the case of a subcontract with a subcontracting plan, with the entity that awarded the subcontract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over the applicable threshold specified in FAR 19.702(a), and the contract contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F**Measures and contributions to performance areas and scores for 2021 Performance and 2022 Service Charge**

To be performed in accordance with the 2021 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment Methodology Carrier Letter (CL 2020-15). The Service Charge for the 2022 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Comprehensive Diabetes Care (HbA1c <8.0%)	CDC	HEDIS	1	2.50
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	1	2.50
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB(18-64)	HEDIS	2	1.25
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS	HEDIS	2	1.25

	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dep. (30 Day)	FUA30	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM30	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	SPC	HEDIS	2	1.25
	Well-Child Visits in the First 30 Months of Life (First 15 Months)	W30(15)	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00
	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain	LBP	HEDIS	1	2.50

Exhibit K

**FEDERAL EMPLOYEES
HEALTH BENEFITS PROGRAM**

**Standard Contract
Amendment**

For

Fee-For-Service Carriers

2023

AMENDMENT TO CONTRACT CS XXXX

CONTRACT NO: 1039
EFFECTIVE: January 1, 2023

AMENDMENT NO. 2023A
EFFECTIVE: January 1, 2023

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G Street, NW
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

FOR THE GOVERNMENT

William A. Breskin

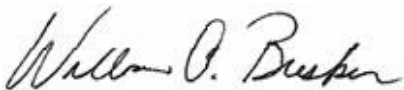
Sylvia V. Pulley

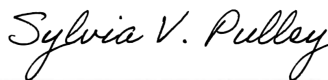
Name of Person Authorized to
Execute Contract

Name of Contracting Officer

Title: Senior Vice President Government
Programs

Title: Contracting Officer





Signature

Signature

12/19/2022

12/28/2022

Date Signed

Date Signed

1. Section 1.5 Enrollment Records and Information

This section changes the title of Section 1.5 and adds a new paragraph (f) that links the quality and timeliness of a Carrier's Master Enrollment Index (MEI) file submissions to its score for the Contract Oversight performance area of the Plan Performance Assessment.

SECTION 1.5

ENROLLMENT RECORDS AND INFORMATION (JAN 2023)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, Tribal Employer, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The Carrier is entitled to rely on information furnished to it under paragraph (a). OPM agrees that any liabilities incurred under this contract in reliance upon such information shall be a valid charge against the contract. Errors or delays in keeping or reporting data relating to coverage shall not invalidate coverage that would otherwise be validly in force and shall not continue coverage that would otherwise be terminated. OPM shall make an equitable adjustment of premiums upon discovery of errors or delays under this Section.

(c) Clerical error (whether by OPM, any other agency, Tribal Employer, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. OPM shall make an equitable adjustment of premiums when an error, delay, or failure is discovered. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract and in what amount or to what extent. Any claim payments the Carrier makes before an adjustment or determination shall be a valid charge against this contract.

(d) The OPM shall direct the agencies and Tribal Employers to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government, the Tribal Employer, or the FEHB Clearinghouse.

(e) In instances of erroneous enrollments where benefit payments have been made in error, the Carrier must inform Enrollees within forty-five days of when the Carrier receives notification from the agency or the Tribal Employer that the Carrier will collect for these benefit payments. The Carrier shall provide notice to the Enrollees that they have the right to contest their enrollment change with their agency, Tribal Employer, or their retirement system.

(f) The Carrier shall submit enrollment data files on an ongoing basis to OPM's Master Enrollment Index (MEI) in a form and manner prescribed by OPM. The Carrier's enrollment data files must provide timely, accurate, and complete information to the MEI.

2. Section 2.2 Benefits Provided

This section amends (h)(2)(ii) that references the 2013 HHS regulation (45 C.F.R. 146.136).

SECTION 2.2

BENEFITS PROVIDED (JAN 2023)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(b) In addition to providing benefits in accordance with (a) above, the Carrier shall be authorized to modify them as follows:

(1) To permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) To pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c) The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with the Rehabilitation Act of 1973, in the case of a Member who is a qualified individual with a disability, the Carrier shall pay for or provide a covered health service or supply as an alternative benefit appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

(2)(i) An OPM requirement under (h)(1) is subject to ongoing review by OPM and the Carrier. Members must cooperate with the review process. If, in the Carrier's judgment, the conditions for the OPM requirement are no longer satisfied, the Carrier may request that OPM modify or terminate the requirement. OPM's decision to modify or terminate a requirement shall be subject to judicial review.

(ii) The Carrier agrees that its benefits as described in the brochure found at Appendix A, are reasonably and in good faith expected to result in coverage that satisfies the Mental Health Parity and Addiction Equity Act, as amended.

(i) In accordance with Section 2706(a) of the Public Health Service Act as added by the Affordable Care Act, the Carrier shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require the Carrier to contract with any health care provider willing to abide by the terms and conditions for participation established by the carrier. Nothing in this section shall be construed as preventing a Carrier from establishing varying reimbursement rates based on quality or performance measures.

3. Section 4.1 Alterations in Contract

Updated to correct typographical error and to align with terms used in FAR 52.232-33 and Section 5.58 of the contract.

SECTION 4.1

ALTERATIONS IN CONTRACT (JAN 1998) (FAR 52.252-4)

Portions of this contract are altered as follows:

(--) Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(--) Section 1.14, *Misleading, Deceptive, or Unfair Advertising*, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation. Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(--) Section 5.58. The reference to System for Award Management (SAM) in FAR 52.232-33, Payment by Electronic Funds Transfer-System for Award Management (SAM), is not applicable to this contract.

4. Section 5.44 Authorized Deviations in Clauses

Correction to the FAR Citation Date

SECTION 5.44

AUTHORIZED DEVIATIONS IN CLAUSES (NOV 2020) (FAR 52.252-6)

5. Section 5.47 Protecting the Government's Interest when Subcontracting With Contractors Debarred, Suspended or Proposed For Debarment

Updated per changes to the FAR

SECTION 5.47

PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (NOV 2021) (FAR 52.209-6)

(a) Definition. "Commercially available off-the-shelf (COTS)" item, as used in this clause—

(1) Means any item of supply (including construction material) that is—

(i) A commercial product (as defined in paragraph (1) of the definition of "commercial product" in Federal Acquisition Regulation (FAR) 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

(b) The Government suspends or debar Contractors to protect the Government's interests. Other than a subcontract for a commercially available off-the-shelf item, the Contractor shall not enter into any subcontract, in excess of the threshold specified in FAR 9.405-2(b) on the date of subcontract award with a Contractor that is debarred, suspended, or proposed for debarment by any executive agency unless there is a compelling reason to do so.

(c) The Contractor shall require each proposed subcontractor whose subcontract will exceed the threshold specified in FAR 9.405-2(b) on the date of subcontract award, other than a subcontractor providing a commercially available off-the-shelf item, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(d) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party (other than a subcontractor providing a commercially available off-the-shelf item) that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the System for Award Management (SAM) Exclusions). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being listed with an exclusion in SAM.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its being listed with an exclusion in SAM.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(e) Subcontracts. Unless this is a contract for the acquisition of commercial products or commercial services, the Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for the identification of the parties), in each subcontract that—

- (1) Exceeds the threshold specified in FAR 9.405-2(b) on the date of subcontract award;
- and
- (2) Is not a subcontract for commercially available off-the-shelf items.

6. Section 5.56 Authorization and Consent

Correction to the FAR Citation Date

SECTION 5.56

AUTHORIZATION AND CONSENT (JUN 2020) (FAR 52.227-1)

7. Section 5.60 Subcontracts for Commercial Products and Commercial Services

Updated per changes to the FAR

SECTION 5.60

SUBCONTRACTS FOR COMMERCIAL PRODUCTS AND COMMERCIAL SERVICES
(JAN 2022) (FAR 52.244-6)

(a) Definitions. As used in this clause —

“Commercial product,” “commercial service,” and “commercially available off-the-shelf item” have the meanings contained in Federal Acquisition Regulation 2.101.

“Subcontract” includes a transfer of commercial products or commercial services between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial products, commercial services, or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial products or commercial services:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (NOV 2021) (41 U.S.C. 3509), if the subcontract exceeds the threshold specified in FAR 3.1004(a) on the date of subcontract award, and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204-21, Basic Safeguarding of Covered Contractor Information Systems (NOV 2021), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204-21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (NOV 2021) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (NOV 2021) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (OCT 2018) (15 U.S.C. 637(d)(2) and (3)) if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds, the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)

(ix) 52.222-26, Equal Opportunity (Sep 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Jun 2020) (38 U.S.C. 4212(a).

(xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jun 2020) (29 U.S.C. 793).

(xii) 52.222-37, Employment Reports on Veterans (Jun 2020) (38 U.S.C. 4212).

(xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xiv)(A) 52.222-50, Combating Trafficking in Persons (NOV 2021) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xv) 52.222-55, Minimum Wages for Contractor Workers under Executive Order 14026 (JAN 2022), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.

(xvi) 52.222-62, Paid Sick Leave Under Executive Order 13706 (JAN 2022) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.

(xvii) (A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).

(xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (NOV 2021) if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (NOV 2021) 46 U.S.C. 55305 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial products or commercial services a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

8. Section 5.64 Contractor Code of Business Ethics and Conduct

Updated per changes to the FAR

SECTION 5.64

CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (NOV 2021) (FAR 52.203–13).

(a) *Definitions.* As used in this clause--

Agent means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization.

Full cooperation--(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;

(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require--

(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or

(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and

(3) Does not restrict a Contractor from--

(i) Conducting an internal investigation; or

(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

"Principal" means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a division, or business segment; and similar positions).

"Subcontract" means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"Subcontractor" means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.

"United States" means the 50 States, the District of Columbia, and outlying areas.

(b) *Code of business ethics and conduct.*

(1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall--

(i) Have a written code of business ethics and conduct; and

(ii) Make a copy of the code available to each employee engaged in performance of the contract.

(2) The Contractor shall--

- (i) Exercise due diligence to prevent and detect criminal conduct; and
- (ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

(3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed--

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or

(B) A violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked "confidential" or "proprietary" by the company.

To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract.

(c) Business ethics awareness and compliance program and internal control system. This paragraph (c) does not apply if the Contractor has represented itself as a small business concern pursuant to the award of this contract or if this contract is for the acquisition of a commercial product or commercial service as defined at FAR 2.101. The Contractor shall establish the following within 90 days after contract award, unless the Contracting Officer establishes a longer time period:

(1) An ongoing business ethics awareness and compliance program.

(i) This program shall include reasonable steps to communicate periodically and in a practical manner the Contractor's standards and procedures and other aspects of the Contractor's business ethics awareness and compliance program and internal control system, by conducting effective training programs and otherwise disseminating information appropriate to an individual's respective roles and responsibilities.

(ii) The training conducted under this program shall be provided to the Contractor's principals and employees, and as appropriate, the Contractor's agents and subcontractors.

(2) An internal control system.

(i) The Contractor's internal control system shall--

(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and

(B) Ensure corrective measures are promptly instituted and carried out.

(ii) At a minimum, the Contractor's internal control system shall provide for the following:

(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.

(B) Reasonable efforts not to include an individual as a principal, whom due diligence would have exposed as having engaged in conduct that is in conflict with the Contractor's code of business ethics and conduct.

(C) Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process.

(D) An internal reporting mechanism, such as a hotline, which allows for anonymity or confidentiality, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(E) Disciplinary action for improper conduct or for failing to take reasonable steps to prevent or detect improper conduct.

(F) Timely disclosure, in writing, to the agency OIG, with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of any Government contract performed by the Contractor or a subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 U.S.C. or a violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(1) If a violation relates to more than one Government contract, the Contractor may make the disclosure to the agency OIG and Contracting Officer responsible for the largest dollar value contract impacted by the violation.

(2) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract, and the respective agencies' contracting officers.

(3) The disclosure requirement for an individual contract continues until at least 3 years after final payment on the contract.

(4) The Government will safeguard such disclosures in accordance with paragraph (b)(3)(ii) of this clause.

(G) Full cooperation with any Government agencies responsible for audits, investigations, or corrective actions.

(d) Subcontracts. (1) The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts that exceed the threshold specified in FAR 3.1004(a) on the date of subcontract award and a performance period of more than 120 days.

(2) In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

9. Section 5.65 Employment Eligibility Verification

Updated per changes to the FAR

SECTION 5.65

EMPLOYMENT ELIGIBILITY VERIFICATION (MAY 2022) (FAR 52.222-54).

(a) Definitions. As used in this clause—

“Commercially available off-the-shelf (COTS) item”—

(1) Means any item of supply that is—

(i) A commercial product (as defined in paragraph (1) of the definition of “commercial product” at Federal Acquisition Regulation (FAR) 2.101;

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products. Per 46 CFR 525.1(c)(2), “bulk cargo” means cargo that is loaded and carried in bulk onboard ship without mark or count, in a loose unpackaged form, having homogenous characteristics. Bulk cargo loaded into intermodal equipment, except LASH or Seabee barges, is subject to mark and count and, therefore, ceases to be bulk cargo.

Employee assigned to the contract means an employee who was hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), who is directly performing work, in the United States, under a contract that is required to include the clause prescribed at 22.1803. An employee is not considered to be directly performing work under a contract if the employee-

(1) Normally performs support work, such as indirect or overhead functions; and

(2) Does not perform any substantial duties applicable to the contract.

Subcontract means any contract, as defined in 2.101, entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime Contractor or another subcontractor.

United States, as defined in 8 U.S.C. 1101(a)(38), means the 50 States, the District of Columbia, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands.

(b) Enrollment and verification requirements.

(1) If the Contractor is not enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall—

(i) Enroll. Enroll as a Federal Contractor in the E-Verify program within 30 calendar days of contract award;

(ii) Verify all new employees. Within 90 calendar days of enrollment in the E-Verify program, begin to use E-Verify to initiate verification of employment eligibility of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); and

(iii) Verify employees assigned to the contract. For each employee assigned to the contract, initiate verification within 90 calendar days after date of enrollment or within 30

calendar days of the employee's assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(2) If the Contractor is enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall use E-Verify to initiate verification of employment eligibility of—

(i) All new employees.

(A) Enrolled 90 calendar days or more. The Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(B) Enrolled less than 90 calendar days. Within 90 calendar days after enrollment as a Federal Contractor in E-Verify, the Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(ii) Employees assigned to the contract. For each employee assigned to the contract, the Contractor shall initiate verification within 90 calendar days after date of contract award or within 30 days after assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(3) If the Contractor is an institution of higher education (as defined at 20 U.S.C. 1001(a)); a State or local government or the government of a Federally recognized Indian tribe; or a surety performing under a takeover agreement entered into with a Federal agency pursuant to a performance bond, the Contractor may choose to verify only employees assigned to the contract, whether existing employees or new hires. The Contractor shall follow the applicable verification requirements at (b)(1) or (b)(2) respectively, except that any requirement for verification of new employees applies only to new employees assigned to the contract.

(4) Option to verify employment eligibility of all employees. The Contractor may elect to verify all existing employees hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), rather than just those employees assigned to the contract. The Contractor shall initiate verification for each existing employee working in the United States who was hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), within 180 calendar days of—

(i) Enrollment in the E-Verify program; or

(ii) Notification to E-Verify Operations of the Contractor's decision to exercise this option, using the contact information provided in the E-Verify program Memorandum of Understanding (MOU).

(5) The Contractor shall comply, for the period of performance of this contract, with the requirements of the E-Verify program MOU.

(i) The Department of Homeland Security (DHS) or the Social Security Administration (SSA) may terminate the Contractor's MOU and deny access to the E-Verify system in accordance with the terms of the MOU. In such case, the Contractor will be referred to a suspension or debarment official.

(ii) During the period between termination of the MOU and a decision by the suspension or debarment official whether to suspend or debar, the Contractor is excused from its obligations under paragraph (b) of this clause. If the suspension or debarment official determines not to suspend or debar the Contractor, then the Contractor must reenroll in E-Verify.

(c) Web site. Information on registration for and use of the E-Verify program can be obtained via the Internet at the Department of Homeland Security Web site: <https://www.e-Verify.gov>.

(d) Individuals previously verified. The Contractor is not required by this clause to perform additional employment verification using E-Verify for any employee –

(1) Whose employment eligibility was previously verified by the Contractor through the E-Verify program;

(2) Who has been granted and holds an active U.S. Government security clearance for access to confidential, secret, or top secret information in accordance with the National Industrial Security Program Operating Manual; or

(3) Who has undergone a completed background investigation and been issued credentials pursuant to Homeland Security Presidential Directive (HSPD)-12, Policy for a Common Identification Standard for Federal Employees and Contractors.

(e) Subcontracts. The Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for identification of the parties), in each subcontract that -

(1) Is for

(i) Services (except for commercial services that are part of the purchase of a COTS item (or an item that would be a COTS item, but for minor modifications), performed by the COTS provider, and are normally provided for that COTS item); or

(ii) Construction;

(2) Has a value of more than \$3,500; and

(3) Includes work performed in the United States.

10. Section 5.71 Combating Trafficking in Persons

Updated per changes to the FAR

SECTION 5.71

COMBATING TRAFFICKING IN PERSONS (NOV 2021) (FAR 52.222-50)

(a) Definitions. As used in this clause—

“Agent” means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.

“Coercion” means—

(1) Threats of serious harm to or physical restraint against any person;

(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

(3) The abuse or threatened abuse of the legal process. “Commercial sex act” means any sex act on account of which anything of value is given to or received by any person.

“Commercially available off-the-shelf (COTS) item”

(1) Means any item of supply (including construction material) that is-

(i) A commercial product (as defined in paragraph (1) of the definition of “commercial product” at Federal Acquisition Regulation (FAR) 2.101;

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

“Debt bondage” means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

“Employee” means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.

“Forced Labor” means knowingly providing or obtaining the labor or services of a person—

(1) By threats of serious harm to, or physical restraint against, that person or another person;

(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or

(3) By means of the abuse or threatened abuse of law or the legal process.

“Involuntary servitude” includes a condition of servitude induced by means of—

(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or

(2) The abuse or threatened abuse of the legal process.

“Recruitment fees” means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.

(1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

(i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;

(ii) Advertising;

(iii) Obtaining permanent or temporary labor certification, including any associated fees;

(iv) Processing applications and petitions;

(v) Acquiring visas, including any associated fees;

(vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;

(vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;

(viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;

(ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;

(x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;

(xi) Transportation and subsistence costs—

(A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and

(B) From the airport or disembarkation point to the worksite;

(xii) Security deposits, bonds, and insurance; and

(xiii) Equipment charges.

(2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—

(i) Paid in property or money;

(ii) Deducted from wages;

(iii) Paid back in wage or benefit concessions;

(iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or

(v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—

(A) Agents;

(B) Labor brokers;

(C) Recruiters;

(D) Staffing firms (including private employment and placement firms);

(E) Subsidiaries/affiliates of the employer;

(F) Any agent or employee of such entities; and

(G) Subcontractors at all tiers.

“Severe forms of trafficking in persons” means—

(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

“Sex trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

“Subcontract” means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

“Subcontractor” means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor.

“United States” means the 50 States, the District of Columbia, and outlying areas.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;

(2) Procure commercial sex acts during the period of performance of the contract; or

(3) Use forced labor in the performance of the contract.

(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee’s identity or immigration documents, such as passports or drivers’ licenses, regardless of issuing authority;

(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant cost to be charged to the employee or potential employee, and, if applicable, the hazardous nature of the work;

(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;

(6) Charge employees or potential employees recruitment fees;

(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-

(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or

(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that-

(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-

(A) Legally permitted to remain in the country of employment and who chooses to do so; or

(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;

(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.

(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or

(9) If required by law or contract, fail to provide an employment contract, recruitment agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) *Notification.*

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i) Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud) ; and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) *Remedies.* In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) *Mitigating and aggravating factors.* When determining remedies, the Contracting Officer may consider the following:

(1) *Mitigating factors.* The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.

(2) *Aggravating factors.* The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.

(g) *Full cooperation.*

(1) The Contractor shall, at a minimum-

(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;

(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;

(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and

(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.

(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-

(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;

(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or

(iii) Restrict the Contractor from-

(A) Conducting an internal investigation; or

(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

(h) Compliance plan.

(1) This paragraph (h) applies to any portion of the contract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds \$550,000.

(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-

(i) To the size and complexity of the contract; and

(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.

(3) Minimum requirements. The compliance plan must include, at a minimum, the following:

(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can be found at the website for the Department of State's Office to Monitor and Combat Trafficking in Persons at <http://www.state.gov/j/tip/>.

(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all

employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888-FREE and its email address at help@befree.org.

(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employees or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.

(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.

(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.

(4) Posting.

(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.

(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.

(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-

(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and

(ii) After having conducted due diligence, either-

(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or

(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.

(i) *Subcontracts.*

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds \$550,000.

(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

11. Section 5.72 Basic Safeguarding of Covered Contractor Information Systems Updated per changes to the FAR

SECTION 5.72

BASIC SAFEGUARDING OF COVERED CONTRACTOR INFORMATION SYSTEMS
(NOV 2021) (FAR 52.204-21)

(a) Definitions. As used in this clause Covered contractor information system means an information system that is owned or operated by a contractor that processes, stores, or transmits Federal contract information.

Federal contract information means information, not intended for public release, that is provided by or generated for the Government under a contract to develop or deliver a product or service to the Government, but not including information provided by the Government to the public (such as on public websites) or simple transactional information, such as necessary to process payments.

Information means any communication or representation of knowledge such as facts, data, or opinions, in any medium or form, including textual, numerical, graphic, cartographic, narrative, or audiovisual (Committee on National Security Systems Instruction (CNSSI) 4009).

Information system means a discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of information (44 U.S.C. 3502).

Safeguarding means measures or controls that are prescribed to protect information systems.

(b) Safeguarding requirements and procedures. (1) The Contractor shall apply the following basic safeguarding requirements and procedures to protect covered contractor information systems. Requirements and procedures for basic safeguarding of covered contractor information systems shall include, at a minimum, the following security controls:

- (i) Limit information system access to authorized users, processes acting on behalf of authorized users, or devices (including other information systems).
- (ii) Limit information system access to the types of transactions and functions that authorized users are permitted to execute.
- (iii) Verify and control/limit connections to and use of external information systems.
- (iv) Control information posted or processed on publicly accessible information systems.
- (v) Identify information system users, processes acting on behalf of users, or devices.
- (vi) Authenticate (or verify) the identities of those users, processes, or devices, as a prerequisite to allowing access to organizational information systems.
- (vii) Sanitize or destroy information system media containing Federal Contract Information before disposal or release for reuse.
- (viii) Limit physical access to organizational information systems, equipment, and the respective operating environments to authorized individuals.
- (ix) Escort visitors and monitor visitor activity; maintain audit logs of physical access; and control and manage physical access devices.

(x) Monitor, control, and protect organizational communications (i.e., information transmitted or received by organizational information systems) at the external boundaries and key internal boundaries of the information systems.

(xi) Implement subnetworks for publicly accessible system components that are physically or logically separated from internal networks.

(xii) Identify, report, and correct information and information system flaws in a timely manner.

(xiii) Provide protection from malicious code at appropriate locations within organizational information systems.

(xiv) Update malicious code protection mechanisms when new releases are available.

(xv) Perform periodic scans of the information system and real-time scans of files from external sources as files are downloaded, opened, or executed.

(2) Other requirements. This clause does not relieve the Contractor of any other specific safeguarding requirements specified by Federal agencies and departments relating to covered contractor information systems generally or other Federal safeguarding requirements for controlled unclassified information (CUI) as established by Executive Order 13556.

(c) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (c), in subcontracts under this contract (including subcontracts for the acquisition of commercial products or commercial services, other than commercially available off-the-shelf items), in which the subcontractor may have Federal contract information residing in or transiting through its information system.

12. Section 5.74 Prohibition On Contracting For Hardware, Software, And Services Developed Or Provided By Kaspersky Lab And Other Covered Entities

Updated per changes to the FAR

SECTION 5.74

PROHIBITION ON CONTRACTING FOR HARDWARE, SOFTWARE, AND SERVICES DEVELOPED OR PROVIDED BY KASPERSKY LAB AND OTHER COVERED ENTITIES (NOV 2021) (FAR 52.204-23).

(a) *Definitions.* As used in this clause—

“Covered article” means any hardware, software, or service that—

(1) Is developed or provided by a covered entity;

(2) Includes any hardware, software, or service developed or provided in whole or in part by a covered entity; or

(3) Contains components using any hardware or software developed in whole or in part by a covered entity.

“Covered entity” means—

(1) Kaspersky Lab;

(2) Any successor entity to Kaspersky Lab;

(3) Any entity that controls, is controlled by, or is under common control with Kaspersky Lab; or

(4) Any entity of which Kaspersky Lab has a majority ownership.

(b) *Prohibition.* Section 1634 of Division A of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. 115-91) prohibits Government use of any covered article. The Contractor is prohibited from—

(1) Providing any covered article that the Government will use on or after October 1, 2018; and

(2) Using any covered article on or after October 1, 2018, in the development of data or deliverables first produced in the performance of the contract.

(c) *Reporting requirement.*

(1) In the event the Contractor identifies a covered article provided to the Government during contract performance, or the Contractor is notified of such by a subcontractor at any tier or any other source, the Contractor shall report, in writing, to the Contracting Officer or, in the case of the Department of Defense, to the website at <https://dibnet.dod.mil>. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at <https://dibnet.dod.mil>.

(2) The Contractor shall report the following information pursuant to paragraph (c)(1) of this clause:

(i) Within 1 business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; brand; model number (Original Equipment Manufacturer (OEM) number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the report pursuant to paragraph (c)(1) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of a covered article, any reasons that led to the use or submission of the covered article, and any additional efforts that will be incorporated to prevent future use or submission of covered articles.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts including subcontracts for the acquisition of commercial products or commercial services.

13. Section 5.75 Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment

Updated per changes to the FAR

SECTION 5.75

PROHIBITION ON CONTRACTING FOR CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT (NOV 2021) (FAR 52.204-25).

(a) *Definitions.* As used in this clause—

“Backhaul” means intermediate links between the core network, or backbone network, and the small subnetworks at the edge of the network (e.g., connecting cell phones/towers to the core telephone network). Backhaul can be wireless (e.g., microwave) or wired (e.g., fiber optic, coaxial cable, Ethernet).

“Covered foreign country” means The People’s Republic of China.

“Covered telecommunications equipment or services” means—

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

“Critical technology” means—

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled—

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

“Interconnection arrangements” means arrangements governing the physical connection of two or more networks to allow the use of another’s network to hand off traffic where it is ultimately delivered (e.g., connection of a customer of telephone provider A to a customer of telephone company B) or sharing data and other information resources.

“Reasonable inquiry” means an inquiry designed to uncover any information in the entity’s possession about the identity of the producer or provider of covered

telecommunications equipment or services used by the entity that excludes the need to include an internal or third-party audit.

“Roaming” means cellular communications services (e.g., voice, video, data) received from a visited network when unable to connect to the facilities of the home network either because signal coverage is too weak or because traffic is too high.

“Substantial or essential component” means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) *Prohibition.* (1) Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104.

(2) Section 889(a)(1)(B) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2020, from entering into a contract, or extending or renewing a contract, with an entity that uses any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104. This prohibition applies to the use of covered telecommunications equipment or services, regardless of whether that use is in performance of work under a Federal contract.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) *Reporting requirement.* (1) In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at <https://dibnet.dod.mil>. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at <https://dibnet.dod.mil>.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(a) *Subcontracts*. The Contractor shall insert the substance of this clause, including this paragraph (e) and excluding paragraph (b)(2), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial products or commercial services.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1

ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance - Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term “repeated” in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member’s insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2

HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3

DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as “Participating Plans”).

SECTION 4.4

AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM’s Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier’s and Participating Plans’ performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5

ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6

TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

- (i) the actual aggregate charges for those costs, or
- (ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7

MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8

PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9

SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10

LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11

PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12

TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13

PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals: the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}} \right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:

(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or

(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I

SECTION 4.14

FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports \$900 on IRS Form 8963 and pays \$500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$500 HIP Fee, F's Form 8963 reflects that \$300 is attributable to F's FEHBP business.

Also in 2015, G reports \$950 on IRS Form 8963 and pays \$550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the \$550 HIP Fee, G's Form 8963 reflects that \$325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $\$300 + \$325 = \$725$, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of \$300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: $(\$300/1-.35)-\$300 = \$162$

Local Plan G HIP Tax Cost: $(\$325/1-.20)-\$325 = \$81$

Sum which is C's allowable HIP Tax Cost for 2015 = \$243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of $300 + 325 = \$725$, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of \$325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by \$325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162

Local Plan G HIP Tax Cost for 2016 = 0

Reimbursement attributable to G = adjustment for amounts drawn down by C, if any

Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes \$162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes \$81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of \$325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as \$325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less \$325.]

Local Plan F HIP Tax Cost for 2017 = 162

Local Plan G HIP Tax Cost for 2017 = 81

Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% = 81

Sum = C's allowable HIP Tax Cost for 2017 = $162 + 81 + 81 = \$324$

APPENDIX A

ATTACH

2023 FEHB BROCHURE

APPENDIX B**SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS**

Fee-For-Service Carrier
(Blue Cross and Blue Shield Association)

CONTRACT NO. CS 1039
Effective January 1, 2023

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

\$333.07 Self, \$748.48 Self Plus One, and \$816.66 Family BASIC Option
\$386.65 Self, \$845.55 Self Plus One, and \$922.41 Family STANDARD Option
\$208.52 Self, \$448.25 Self Plus One, and \$493.06 Family FOCUS Option

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

<u>Item</u>	<u>Amount</u>
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2023, * plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	

*The Contractual Expense Limitation for 2023 is [REDACTED]. Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2023 contract year is based on the Overall Performance Score calculated in accordance with the 2022 Appendix F. The Service Charge for the 2024 contract year will be based on the Overall Performance Score calculated in accordance with the 2023 Appendix F.

APPENDIX E

Small Business Subcontracting Plan (NOV 2021) (FAR 52.219-9)

(a) This clause does not apply to small business concerns.

(b) *Definitions.* As used in this clause—

“Alaska Native Corporation (ANC)” means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

“Commercial plan” means a subcontracting plan (including goals) that covers the offeror’s fiscal year and that applies to the entire production of commercial products and commercial services sold by either the entire company or a portion thereof (e.g., division, plant, or product line).

“Commercial product” means a product that satisfies the definition of “commercial product” in the Federal Acquisition Regulation (FAR) 2.101.

“Commercial service” means a service that satisfies the definition of “commercial service” in FAR 2.101.

“Indian tribe” means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

“Individual subcontracting plan” means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror’s planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

“Master subcontracting plan” means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

“Reduced payment” means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

“Subcontract” means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

“Total contract dollars” means the final anticipated dollar value, including the dollar value of all options.

“Untimely payment” means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c) (1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if—

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The offeror's subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626—

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts, including all indirect costs except as described in paragraph (g) of this clause, to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns (including ANC and Indian tribes); and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (e.g., existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in SAM as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM as its source list does not relieve a firm of its

responsibilities (*e.g.*, outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

- (i) Small business concerns (including ANC and Indian tribes);
- (ii) Veteran-owned small business concerns;
- (iii) Service-disabled veteran-owned small business concerns;
- (iv) HUBZone small business concerns;
- (v) Small disadvantaged business concerns; and
- (vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

- (i) Cooperate in any studies or surveys as may be required;
- (ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;
- (iii) After November 30, 2017, include subcontracting data for each order when reporting subcontracting achievements for indefinite-delivery, indefinite-quantity contracts with individual subcontracting plans where the contract is intended for use by multiple agencies;
- (iv) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (1) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (1) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations;
- (v) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (1) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (1) of this clause
- (vi) [RESERVED]; and
- (vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own unique entity identifier, and the e-mail address of the subcontractor's

official responsible for acknowledging receipt of or rejecting the Standard Forms 294, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.*, SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if—

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror

in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial products and commercial services. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial product or commercial service. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. A Contractor authorized to use a commercial subcontracting plan shall include in its subcontracting goals and in its SSR all indirect costs, with the exception of those such as the following: Employee salaries and benefits; payments for petty cash; depreciation; interest; income taxes; property taxes; lease payments; bank fees; fines, claims, and dues; original equipment manufacturer relationships during warranty periods (negotiated up front with the product); utilities and other services purchased from a municipality or an entity solely authorized by the municipality to provide those services in a particular geographical region; and philanthropic contributions. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at FAR 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Products and Commercial Services, or when the

subcontractor provides a commercial product or commercial service subject to the clause at FAR 52.244-6, Subcontracts for Commercial Products and Commercial Services, under a prime contract.

(k) The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled “Utilization Of Small Business Concerns,” or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(i) When a subcontracting plan includes indirect costs in the goals, these costs must be included in this report.

(ii) The authority to acknowledge receipt or reject the SF 294 resides—

(A) In the case of the prime Contractor, with the Contracting Officer; and

(B) In the case of a subcontract with a subcontracting plan, with the entity that awarded the subcontract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over the applicable threshold specified in FAR 19.702(a), and the contract contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F

Measures and contributions to performance areas and scores for 2023 Performance and 2024 Service Charge

To be performed in accordance with the 2023 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment Methodology Carrier Letter (CL 2020-15). The Service Charge for the 2024 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB	HEDIS	1	2.50
	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Hemoglobin A1c Control for Patients with Diabetes (HbA1c Control <8.0%)	HBD	HEDIS	1	2.50
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS	HEDIS	2	1.25

Clinical Quality	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Substance Use (30 Day)	FUA	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Statin Adherence 80%)	SPC	HEDIS	2	1.25
	Well Child Visits First 30 Months of Life – Well-Child Visits in the First 15 months: 6 or More Well-Child Visits	W30	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00

	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain (18-64)	LBP	HEDIS	1	2.50
	Acute Hospital Utilization	AHU	HEDIS	2	1.25
	Emergency Department Utilization	EDU	HEDIS	2	1.25
	Plan All Cause Readmissions: Observed/Expected (O/E) Ratio	PCR	HEDIS	2	1.25

Exhibit L

Blue Cross® and Blue Shield® Service Benefit Plan

<http://www.fepblue.org>



2013

A fee-for-service plan (standard and basic option) with a preferred provider organization

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

- 104 Standard Option - Self Only
- 105 Standard Option - Self and Family
- 111 Basic Option - Self Only
- 112 Basic Option - Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2013: Page 14
- Summary of benefits: Page 158



The Case Management programs for this Plan are accredited through URAC or NCQA, or through Health Plan accreditation from NCQA.



This Plan has Health Web Site accreditation from URAC.

See the 2013 FEHB Guide for more information on accreditation.



Authorized for distribution by the:



United States
Office of Personnel Management

Healthcare and Insurance
<http://www.opm.gov/insure>

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. For customer service assistance, visit our Web site, www.fepblue.org, or contact your Local Plan at the telephone number appearing on the back of your ID card.

The Blue Cross and Blue Shield Association is the Carrier of the Plan. The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan

1310 G Street, NW, Suite 900

Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2013, and changes are summarized on pages 13-14. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.
 - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

1-877-499-7295

OR go to www.opm.gov/oig

You can also write to:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

"Exactly what will you be doing?"

"About how long will it take?"

"What will happen after surgery?"

"How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

Ø www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct never events, if you use Service Benefit Plan Preferred or Member hospitals. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**
- **Where you can get information about enrolling in the FEHB Program**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB Web site at www.opm.gov/insure/lifeevents. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

• **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

• **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2013 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2012 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 1. How this Plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, and select "Provider Directory" to use our National Doctor & Hospital FinderSM. You can reach our Web page through the FEHB Web site, www.opm.gov/insure.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 18 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as "Preferred."** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option only**, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see pages 140-141). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 18 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. **Note:** As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our Web site at www.fepblue.org.

Section 2. Changes for 2013

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (*Benefits*). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- South Carolina has been added to the list of Medically Underserved Areas for 2013; Alaska and Kentucky have been removed from the list. (See page 16.)

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 150.)
- We modified the list of generic drug replacements included in our Standard Option Generic Incentive Program. (See page 96.)
- Your copayment for services provided at a Preferred urgent care center is now \$40 per visit. Previously, you paid 15% of the Plan allowance for these services, after meeting your calendar year deductible. (See page 87.)
- Your copayment for continuous home hospice care performed by a Preferred provider is now \$250 per episode. Previously, your copayment for these services was \$200 per episode. (See page 82.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 150.)
- Your copayment for outpatient physical, occupational, and speech therapy billed for by a Preferred hospital is now \$25 per day per facility. Benefits are limited to a total of 50 visits per person, per calendar year. Previously, your copayment was \$75 per day per facility for these types of services. (See page 78.)
- Your copayment for outpatient cardiac rehabilitation, cognitive rehabilitation, and pulmonary rehabilitation billed for by a Preferred hospital is now \$25 per day per facility. Previously, your copayment for rehabilitative treatment was \$75 per day per facility. (See page 78.)
- Your copayment for the outpatient facility services listed on page 77 in Section 5(c) is now \$100 per day per facility, when you receive those services at a Preferred facility. Previously, your copayment for these services was \$75 per day per facility. (See page 77.)
- Your copayment for the outpatient diagnostic studies and radiological services listed on page 77 in Section 5(c) is now \$100 per day per facility, when you receive those services at a Member or Non-member facility. Previously, your copayment for these services was \$75 per day per facility. (See page 77.)
- Benefits for diagnostic tests related to an accidental injury and performed in settings other than an emergency room or urgent care center may be subject to a copayment of \$25, \$75, or \$100, according to the type of test performed and the provider billing for the test. See pages 35-36 in Section 5(a) and pages 77-79 in Section 5(c) for the benefits levels that apply. Previously, you paid nothing for diagnostic tests related to an accidental injury, regardless of the setting for the tests or the type of provider.
- We now provide benefits in full for agents, drugs, and/or supplies administered or obtained in connection with your care at a Preferred urgent care center. Previously, you paid 30% of the Plan allowance for these types of charges. (See pages 86 and 87.)

Changes to both our Standard and Basic Options

- We now pay up to \$2,500 per calendar year for children's hearing aids and related supplies, up to \$2,500 every 3 calendar years for adult hearing aids and related supplies, and up to \$5,000 per calendar year for bone anchored hearing aids for adults and children. Previously, benefits were limited to \$1,250 per ear per calendar year for children's hearing aids, \$1,250 per ear per 36-month period for adult hearing aids, and \$1,250 per ear per calendar year for bone anchored hearing aids for adults and children. (See page 52.)

- We now provide Preventive Care benefits for Human Papillomavirus (HPV) screening for females once per year. Previously, benefits for HPV screening were included in the benefit for cervical cancer tests. (See pages 37 and 41.)
- We now provide benefits in full for breastfeeding pump kits when obtained through CVS Caremark. Benefits are limited to one kit per year for women who are pregnant and/or nursing. Previously, benefits were not available for these items. (See page 43.)
- We now provide benefits in full for certain contraceptive services and voluntary sterilization procedures for women when the services are performed by a Preferred provider. Previously, these services were subject to member cost-share. (See page 44.)
- We now provide benefits in full for generic contraceptive drugs and devices for women purchased at a Preferred retail or internet pharmacy, or, for Standard Option only, obtained through the Mail Service Prescription Drug Program. Previously, these items were subject to member cost-share. (See page 97.)
- We now provide benefits in full for over-the-counter (OTC) contraceptive drugs and devices for women only, when the contraceptives meet FDA standards for OTC products, and only when they are purchased at a Preferred retail pharmacy with a physician's prescription. Previously, these items were not covered. (See page 98.)
- We now provide benefits for additional types of organ/tissue transplants. (See pages 66-69.)
- We now provide benefits for up to thirty (30) consecutive days of inpatient hospice care performed in a facility licensed as an inpatient hospice facility. Benefits are provided in full for inpatient hospice care performed at a Preferred hospice facility. Previously, benefits were available for up to seven (7) consecutive days of inpatient hospice care. For care performed at a Preferred hospice facility, these benefits were subject to a copayment of \$250 per admission under Standard Option, or \$150 per day (up to \$750 per admission) under Basic Option. (See page 83.)
- We clarified that benefits are not available for services performed or billed by residential treatment centers. (See page 91.)
- Your cost-share for specialty drugs used to treat rare or uncommon conditions that are available only through a Preferred retail pharmacy due to manufacturer restrictions will be consistent with the Specialty Drug Pharmacy Program cost-share. Previously, you paid the Preferred retail pharmacy cost-share. (See pages 93 and 102.)
- We now provide benefits for professional charges for after-hours care (shift differentials) when associated with services provided in a physician's office. Previously, benefits were not available for these types of charges. (See page 121.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail or internet pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 18 for the exceptions to this requirement. Refer to page 11 for more information about Preferred providers.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

Physicians – Doctors of medicine (M.D.); Doctors of osteopathy (D.O.); Doctors of dental surgery (D.D.S.); Doctors of medical dentistry (D.M.D.); Doctors of podiatric medicine (D.P.M.); Doctors of optometry (O.D.); and Doctors of Chiropractic/ chiropractors (D.C.). Reimbursable chiropractic services shall only be those covered services listed under the Chiropractic benefit on page 55; *Manipulative treatment* on page 56 covered services provided in medically underserved areas as described on page 16; and the performance of covered physical therapy evaluations and physical therapy treatment modalities identified on page 48.

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state's applicable licensing or certification requirements and the requirements of the Local Plan. Other covered health care professionals include:

- **Audiologist** – A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Clinical Psychologist** – A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker** – A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator** – A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.

- **Dietician** – A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory**– A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Lactation Consultant** – A person who is licensed as a Registered Nurse in the United States (or appropriate equivalent if providing services overseas) and is licensed or certified as a lactation consultant by a nationally recognized organization.
- **Mental Health or Substance Abuse professional** – A professional who is licensed by the state where the care is provided to provide mental health and/or substance abuse services within the scope of that license.
- **Nurse Midwife** – A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist** – A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic** – A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient "office" services rather than facility charges.
- **Nutritionist** – A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist** – A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant** – A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Other professional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In the states OPM determines are "medically underserved":

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2013, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, and Wyoming.

• **Covered facility providers**

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

Hospital - An institution, or a distinct portion of an institution, that:

1. Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;

2. Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
3. Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

Freestanding Ambulatory Facility— A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

1. Provides services in an outpatient setting;
2. Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
3. Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
4. Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

Blue Distinction Centers®

Certain facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, and Complex and Rare Cancers. These facilities meet objective quality criteria established with input from expert physician panels, surgeons, and other medical professionals. Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise.

We cover facility costs for specialty care at designated Blue Distinction Centers at Preferred benefit levels, which means that your out-of-pocket expenses for specialty facility services are limited.

Facility care that is not part of the Blue Distinction Program is reimbursed according to the network status of the facility. In addition, some Blue Distinction Centers may use professional providers who do not participate in our provider network. Non-participating providers have no agreements with us to limit what they can bill you. This is why it's important to always request Preferred providers for your care. For more information, see pages 25-28 in Section 4, *Your costs for covered services*, or call your Local Plan at the number listed on the back of your ID card. For listings of Preferred providers in your area, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder.

If you are considering covered bariatric surgery, cardiac procedures, knee or hip replacement, spine surgery, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. To locate a Blue Distinction Center, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number listed on the back of your ID card.

Blue Distinction Centers for Transplants®

In addition to Preferred transplant facilities, you have access to Blue Distinction Centers for Transplants. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. We provide enhanced benefits for covered transplant services performed at these designated centers during the transplant period (see page 143 for the definition of "transplant period").

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the \$250 per admission copayment under Standard Option, or the \$150 per day copayment (\$750 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services.

Regular benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period. (Regular benefit levels and cost-sharing amounts also apply to services unrelated to a covered transplant.)

Blue Distinction Centers for Transplants are available for the following types of transplants: heart; heart-lung; single or double lung; liver; pancreas; simultaneous pancreas-kidney; and autologous or allogeneic blood or marrow stem cell (see page 71 for limitations). **Note:** Certain stem cell transplants **must** be performed at a Blue Distinction Centers for Transplants facility (see pages 66-67).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

Cancer Research Facility – A facility that is:

1. A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
2. An NCI-designated Cancer Center; or
3. An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

FACT-Accredited Facility

A facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). FACT-accredited cellular therapy programs meet rigorous standards. Information regarding FACT transplant programs can be obtained by contacting the transplant coordinator at the customer service number listed on the back of your ID card or by visiting www.factwebsite.org.

Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
2. Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
3. Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
4. Services of assistant surgeons;
5. Special provider access situations (contact your Local Plan for more information); or
6. Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

• **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

• **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for *Other services* (called prior approval), are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a pre-service claim for benefits (1) requires precertification or prior approval and (2) will result in a reduction of benefits if you do not obtain precertification or prior approval.

• **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

• **Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay. (See page 17 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital stay. (See page 17 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

• **Other services**

You must obtain prior approval for these services under both Standard and Basic Option:

- **Outpatient surgical services** – The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
 - Outpatient surgery for morbid obesity. **Note: See page 60 for complete surgical requirements;**
 - Outpatient surgical correction of congenital anomalies; and
 - Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- **Outpatient intensity-modulated radiation therapy (IMRT)** – Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer. Contact us at the customer service number listed on the back of your ID card before receiving outpatient IMRT for cancers which require prior approval. We will request the medical evidence we need to make our coverage determination..

- **Hospice care** – Contact us at the customer service number listed on the back of your ID card before obtaining home hospice, continuous home hospice, or inpatient hospice care services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 81 for information about the exception to this requirement.
- **Organ/tissue transplants** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants** – See pages 68 and 69 for the list of conditions covered **only** in clinical trials for blood or marrow stem cell transplants. Contact us at the customer service number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 68 and 69, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility (see page 18) where the procedure is to be delivered.

- **Prescription drugs** – Certain prescription drugs require prior approval. Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 105 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy, through an internet pharmacy, or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under **Standard Option**, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. CVS Caremark, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **\$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 20 or is one of the transplant procedures listed on page 20) – even if the charge will be \$5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

How to request precertification for an admission or get prior approval for Other services

First, you, your representative, your physician, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

• **Non-urgent care claims**

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

• **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review of the claim and notify you of our decision within 72 hours as long as we receive sufficient information to complete the review. (For concurrent care claims that are also urgent care claims, please see *If your treatment needs to be extended* on page 23.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at the telephone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at the telephone number listed on the back of your ID card. If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your claim).

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone us within two business days, a \$500 penalty may apply – see *Warning* under *Inpatient hospital admission* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of *Other services*, you may request a review by following the procedures listed below. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 136 for definition). (If you have already received the service, supply, or treatment, then your claim is a **post-service claim** and you must follow the entire disputed claims process detailed in Section 8.)

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay, or, if applicable, approve your request for prior approval for the service, drug, or supply; or
2. Write to you and maintain our denial; or

3. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayment	<p>A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.</p> <p>Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of \$20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of \$250 per admission. We then pay the remainder of the amount we allow for the covered services you receive.</p> <p>Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.</p> <p>Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.</p>
Deductible	<p>A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.</p> <p>Under Standard Option, the calendar year deductible is \$350 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach \$700. For families of two, each family member must fully satisfy his or her individual deductible before this "family deductible" is considered met.</p> <p>Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.</p> <p>Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$270) has been satisfied.</p> <p>Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.</p> <p>Under Basic Option, there is no calendar year deductible.</p>
Coinsurance	<p>Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. Under Standard Option only, coinsurance does not begin until you have met your calendar year deductible.</p> <p>Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your \$350 calendar year deductible.</p>

If your provider routinely waives your cost

Note: If your provider routinely waives (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges \$100 for a service but routinely waives your 35% Standard Option coinsurance, the actual charge is \$65. We will pay \$42.25 (65% of the actual charge of \$65).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. It is possible for a provider's bill to exceed the plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred or Participating and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges \$250, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our \$100 allowance (\$15). Because of the agreement, your Preferred physician will not bill you for the \$150 difference between our allowance and his/her bill.

Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges \$250 for covered services subject to a \$25 copayment. Even though our allowance may be \$100, you still pay just the \$25 copayment. Because of the agreement, your Preferred physician will not bill you for the \$225 difference between your copayment and his/her bill.

Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 18 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges \$250, but the Plan allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our \$100 allowance (\$35). Because of the agreement, your Participating physician will not bill you for the \$150 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 18 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our Web site, www.fepblue.org, or call us at the customer service number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pages 140-141). For example, you see a Non-participating physician who charges \$250. The Plan allowance is again \$100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the \$100 Plan allowance or \$35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the \$150 difference between our allowance and his/her bill. This means you would pay a total of \$185 (\$35 + \$150) for the Non-participating physician's services, rather than \$15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 18 for the exceptions to this requirement.

The tables appearing below illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only.** **Basic Option** benefit levels for physician care begin on page 34; see page 77 for Basic Option benefit levels that apply to outpatient hospital or ambulatory surgical facility care.

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges \$250 and the Plan allowance is \$100.

Example	Preferred Physician Standard Option	Participating Physician Standard Option	Non-participating Physician Standard Option
Physician's charge	\$250	\$250	\$250
Our allowance	We set it at: \$100	We set it at: \$100	We set it at: \$100
We pay	85% of our allowance: \$85	65% of our allowance: \$65	65% of our allowance: \$65
You owe: Coinsurance	15% of our allowance: \$15	35% of our allowance: \$35	35% of our allowance: \$35
You owe: Copayment	Not applicable	Not applicable	Not applicable
+Difference up to charge?	No: \$0	No: \$0	Yes: \$150
TOTAL YOU PAY	\$15	\$35	\$185

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance (\$100), which you would pay in full, would count toward your deductible.

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges \$5,000. The Plan allowance is \$2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is \$2,500 when the services are provided at a Non-member facility.

Example	Preferred Ambulatory Surgical Facility Standard Option	Member Ambulatory Surgical Facility Standard Option	Non-member Ambulatory Surgical Facility* Standard Option
Facility's charges	\$5,000	\$5,000	\$5,000
Our allowance	We set at: \$2,900	We set at: \$2,900	We set at: \$2,500
We pay	85% of our allowance: \$2,465	65% of our allowance: \$1,885	65% of our allowance: \$1,625
You owe: Coinsurance	15% of our allowance: \$435	35% of our allowance: \$1,015	35% of our allowance: \$875
You owe: Copayment	Not applicable	Not applicable	Not applicable
+Difference up to charge?	No:\$0	No:\$0	Yes:\$2,500
TOTAL YOU PAY	\$435	\$1,015	\$3,375

Note: If you had not met any of your **Standard Option** deductible in the above examples, \$350 of our allowed amount would be applied to your deductible before your coinsurance amount was calculated.

*A Non-member facility may bill you any amount for the services it provides. You are responsible for paying all expenses over our allowance, regardless of the total amount billed, in addition to your calendar year deductible and coinsurance. For example, if you use a Non-member facility that charges \$60,000 for facility care related to outpatient bariatric surgery, and we pay the \$1,625 amount illustrated above, you would owe \$58,375 (\$60,000 - \$1,625 = \$58,375). This example assumes your calendar year deductible has been met.

**Important notice about
Non-participating
providers!**

**Your catastrophic
protection out-of-pocket
maximum for
deductibles, coinsurance,
and copayments**

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for coinsurance and copayments (other than those listed below) exceeds \$7,000 under Standard Option, or \$5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$5,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach \$7,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 25-26;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your calendar year deductible;
- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member facility;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The \$500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-preferred brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 18 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 28 and on this page until the effective date of your new plan.

- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 28 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See pages 13-14 for how our benefits changed this year. Page 148 and page 149 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

Standard Option

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a \$20 copayment for office visits to primary care providers (\$30 for specialists). Standard Option also features a Preferred retail pharmacy program, a Preferred mail service drug program, and a Preferred specialty drug pharmacy program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments (\$25 for primary care providers and \$35 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program and a Preferred specialty drug pharmacy program.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
 - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See below and page 18 for the exceptions to this requirement.**
 - We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	Standard Option	Basic Option
<p>Outpatient professional services of physicians and other health care professionals:</p> <ul style="list-style-type: none">• Consultations• Second surgical opinions• Clinic visits• Office visits• Home visits• Initial examination of a newborn needing definitive treatment when covered under a family enrollment• Pharmacotherapy (medication management) [see Section 5(f) for prescription drug coverage] <p>Note: Please refer to pages 35-36 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a physician, and to pages 77-79 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for the visit charge (No deductible)</p> <p>Preferred specialist: \$30 copayment for the visit charge (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient professional services:</p> <ul style="list-style-type: none">• During a hospital stay• Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission• Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits <p>Note: A consulting physician employed by the hospital is not the attending physician.</p> <ul style="list-style-type: none">• Consultations when requested by the attending physician• Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care• Physical therapy by a physician other than the attending physician• Initial examination of a newborn needing definitive treatment when covered under a family enrollment• Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs you receive while in the hospital]• Second surgical opinion	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Nutritional counseling when billed by a covered provider 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered :</i></p> <ul style="list-style-type: none"> <i>Routine services except for those Preventive care services described on pages 37-41</i> <i>Telephone consultations and online medical evaluation and management services</i> <i>Private duty nursing</i> <i>Standby physicians</i> <i>Routine radiological and staff consultations required by hospital rules and regulations</i> <i>Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)]</i> <p>Note: <i>If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Lab, X-ray and other diagnostic tests	Standard Option	Basic Option
<p>Diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> Blood tests EKGs Laboratory tests Neurological testing Pathology services Urinalysis <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: Nothing</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p>

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests (cont.)	Standard Option	Basic Option
		<p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<p>Diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • EEGs • Ultrasounds • X-rays (including set-up of portable X-ray equipment) <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: \$25 copayment</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.</p>
<p>Diagnostic tests provided, or ordered and billed by a physician, limited to:</p> <ul style="list-style-type: none"> • Bone density tests – diagnostic • CT scans/MRIs/PET scans • Diagnostic angiography • Genetic testing – diagnostic <p>Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient’s medical condition. Diagnostic BRCA testing is covered only for members with a cancer diagnosis. However, genetic screening is not covered.</p> <ul style="list-style-type: none"> • Nuclear medicine • Sleep studies <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: \$75 copayment</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.</p>

Benefit Description	You Pay	
Preventive care, adult	Standard Option	Basic Option
<p>We provide benefits for a comprehensive range of preventive care services for adults age 22 and over, including the preventive services recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). Covered services include:</p> <ul style="list-style-type: none"> • Routine physical examination • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile • Screening for alcohol/substance abuse <p>Note: See page 57 for our coverage of smoking and tobacco cessation treatment.</p> <ul style="list-style-type: none"> • Individual counseling on prevention and reducing health risks <p>Note: Preventive care benefits are not available for group counseling.</p> <ul style="list-style-type: none"> • Genetic counseling and evaluation for women whose family history is associated with an increased risk for harmful mutations in BRCA1 or BRCA2 genes <p>Note: Preventive care benefits are not available for BRCA testing. See page 36 for the benefit levels that apply to diagnostic genetic testing.</p> <ul style="list-style-type: none"> • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Papillomavirus (HPV) for females • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection • Administration and interpretation of a Health Risk Assessment (HRA) questionnaire (see <i>Definitions</i>) <p>Note: As a member of the Service Benefit Plan, you have access to the Blue Cross and Blue Shield HRA, called the “Blue Health Assessment” questionnaire. Completing the questionnaire entitles you to receive special benefit incentives. See Section 5(h) for complete information.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for routine physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	Standard Option	Basic Option
<p>Note: Preventive care benefits for each of the services listed above are limited to one per calendar year.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for routine physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>
<ul style="list-style-type: none"> Colorectal cancer tests, including: <ul style="list-style-type: none"> Fecal occult blood test Screening colonoscopy (see page 59 for our payment levels for colonoscopies performed by a physician to diagnose or treat a specific condition) Sigmoidoscopy Double contrast barium enema 	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p>

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Prostate cancer tests – Prostate Specific Antigen (PSA) test Cervical cancer tests (including Pap tests) Screening mammograms Ultrasound for aortic abdominal aneurysm Osteoporosis screening – annual screening for women age 60 and over <p>Note: Preventive care benefits for each of the services listed above are limited to one per calendar year.</p> <ul style="list-style-type: none"> Nutritional counseling when billed by a covered provider such as a physician, nurse, nurse practitioner, licensed certified nurse midwife, dietician or nutritionist, who bills independently for nutritional counseling services <p>Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services.</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for routine physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>
<p>Routine immunizations [as licensed by the U.S. Food and Drug Administration (FDA)], limited to:</p> <ul style="list-style-type: none"> Hepatitis (Types A and B) for patients with increased risk or family history Herpes Zoster (shingles)* Human Papillomavirus (HPV)* Influenza (flu)* Measles, Mumps, Rubella Meningococcal* Pneumococcal* Tetanus, Diphtheria, Pertussis booster (one every 10 yrs) Varicella 	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p>

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	Standard Option	Basic Option
<p>*Many Preferred retail pharmacies participate in our vaccine network. See page 98 for our coverage of these vaccines when provided by pharmacies in the vaccine network.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: We waive your deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>
<p>Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed on page 35 to certain age ranges, frequencies, and/or other patient-specific indications, including gender.</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Note: See page 99 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: The benefits listed above and on pages 37-38 do not apply to children up to age 22. (See benefits under <i>Preventive care, children</i>, this Section.)</p> <p>Note: A complete list of the preventive care services recommended under the Affordable Care Act is available online at: www.healthcare.gov/law/about/provisions/services/lists.html. Services recommended under the Act and guidelines for health plan coverage are subject to Federal regulations.</p>	See pages 37-38	See pages 37-38
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Genetic screening (including BRCA screening) related to family history of cancer or other disease</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay	
Preventive care, adult (cont.)	Standard Option	Basic Option
<p>Note: See page 36 for our coverage of medically necessary diagnostic genetic testing.</p> <ul style="list-style-type: none"> Group counseling on prevention and reducing health risks Self-administered health risk assessments (other than the Blue Health Assessment) Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans 	All charges	All charges
Preventive care, children	Standard Option	Basic Option
<p>We provide benefits for a comprehensive range of preventive care services for children up to age 22, including the preventive services recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”), and services recommended by the American Academy of Pediatrics (AAP). Covered services include:</p> <ul style="list-style-type: none"> Healthy newborn visits and screenings (inpatient or outpatient) Routine physical examinations Laboratory tests Hearing and vision screenings Routine immunizations as licensed by the U.S. Food and Drug Administration (FDA) limited to: <ul style="list-style-type: none"> Diphtheria, Tetanus, Pertussis Hemophilus Influenza type b (Hib) Hepatitis (Types A and B) Human Papillomavirus (HPV) Inactivated Poliovirus Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Influenza (flu) Varicella <p>Note: U.S. FDA licensure may restrict the use of certain immunizations and vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender.</p> <ul style="list-style-type: none"> Screening for chlamydial infection Screening for gonorrhea infection Screening for Human Papillomavirus (HPV) for females 	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount.</p> <p>Note: We waive the deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: For services billed by Participating/Non-participating providers related to Influenza (flu) vaccines, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>

Preventive care, children - continued on next page

Benefit Description	You Pay	
Preventive care, children (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Screening for Human Immunodeficiency virus (HIV) infection Screening for syphilis infection <p>Note: Benefits for sexually transmitted infection (STI) screening tests are limited to one test per STI per year.</p> <ul style="list-style-type: none"> Nutritional counseling services (see page 38) <p>Note: See page 99 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: If your child receives both preventive and diagnostic services from a Preferred provider on the same day, you are responsible for paying the cost-share for the diagnostic services.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount.</p> <p>Note: We waive the deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. You pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: For services billed by Participating/Non-participating providers related to Influenza (flu) vaccines, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>
Maternity care	Standard Option	Basic Option
<p>Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as:</p> <ul style="list-style-type: none"> Prenatal care (including ultrasound, laboratory, and diagnostic tests) Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) <p>Note: Maternity care benefits are not provided for oral tocolytic agents. See Section 5(f) for prescription drug coverage (including oral tocolytic agents).</p> <p>Note: Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 55.</p> <ul style="list-style-type: none"> Delivery Postpartum care 	<p>Preferred: Nothing (No deductible)</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to \$150 per admission. For outpatient facility services related to maternity, see pages 78.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p>

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Assistant surgeons/surgical assistance if required because of the complexity of the delivery Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant Breastfeeding education and individual coaching on breastfeeding by a physician, physician assistant, nurse midwife, nurse practitioner/clinical specialist, or registered nurse certified lactation consultant <p>Note: See page 43 for our coverage of breast pump kits.</p> <ul style="list-style-type: none"> Mental health treatment for postpartum depression and depression during pregnancy <p>Note: We provide benefits to cover up to 4 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage of mental health visits to Non-preferred providers and benefits for additional mental health services.</p> <p>Note: See page 35 for our coverage of nutritional counseling.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be \$5,000 or more. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.</p>	<p>Preferred: Nothing</p> <p>Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to \$150 per admission. For outpatient facility services related to maternity, see pages 78.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.</p>
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. We cover routine nursery care of the newborn child when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of an infant who requires professional services or non-routine treatment, only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. 		

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	Standard Option	Basic Option
<p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: See page 59 for our payment levels for circumcision.</p>		
<ul style="list-style-type: none"> Breast pump kit, limited to one of the two kits listed below, per calendar year for women who are pregnant and/or nursing <ul style="list-style-type: none"> Ameda Manual pump kit or Ameda Double Electric pump kit <p>Note: The breast pump kit will include a supply of 150 Ameda milk storage bags. You may order Ameda milk storage bags, limited to 150 bags every 90 days, even if you own your own breast pump.</p> <p>Note: Benefits for the breast pump kit and milk storage bags are only available when you order them through CVS Caremark by calling 1-800-262-7890.</p>	Nothing (No deductible)	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest</i> <i>Genetic testing/screening of the baby's father (see page 36 for our coverage of medically necessary diagnostic genetic testing)</i> <i>Childbirth preparation, Lamaze, and other birthing/parenting classes</i> <i>Breast pumps and milk storage bags except as stated on page 43</i> <i>Breastfeeding supplies other than those contained in the breast pump kit described on page 43 including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)</i> <i>Maternity care for women not enrolled in this Plan</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay	
Family Planning	Standard Option	Basic Option
<p>A range of voluntary family planning services for women, limited to:</p> <ul style="list-style-type: none"> • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives <p>Note: We provide benefits for the professional services associated with the fitting, insertion, implantation, or removal of the contraceptives listed above at the payment levels shown here.</p> <ul style="list-style-type: none"> • Voluntary sterilization (tubal ligation or tubal occlusion/tubal blocking procedures only) <p>Note: See page 59 for our coverage of voluntary sterilization for men.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Oral and transdermal contraceptives <p>Note: We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail or internet pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. See Section 5(f) for more information.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Contraceptive devices not described above</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Infertility services	Standard Option	Basic Option
<p>Diagnosis and treatment of infertility, except as shown in <i>Not covered</i></p> <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p>

Infertility services - continued on next page

Benefit Description	You Pay	
Infertility services (cont.)	Standard Option	Basic Option
		<p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:</i> <ul style="list-style-type: none"> - <i>Artificial insemination (AI)</i> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer and Gamete Intrafallopian Transfer (GIFT)</i> - <i>Zygote Intrafallopian Transfer (ZIFT)</i> - <i>Intravaginal insemination (IVI)</i> - <i>Intracervical insemination (ICI)</i> - <i>Intracytoplasmic sperm injection (ICSI)</i> - <i>Intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART and assisted insemination procedures</i> • <i>Cryopreservation or storage of sperm (sperm banking), eggs, or embryos</i> • <i>Infertility drugs used in conjunction with ART and assisted insemination procedures</i> • <i>Services, supplies, or drugs provided to individuals not enrolled in this Plan</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You Pay	
Allergy care	Standard Option	Basic Option
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit; nothing for injections</p> <p>Preferred specialist: \$35 copayment per visit; nothing for injections</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>
Treatment therapies	Standard Option	Basic Option
<p>Outpatient treatment therapies:</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under <i>Organ/tissue transplants</i> in Section 5(b). See also, <i>Other services</i> under <i>You need prior Plan approval for certain services</i> in Section 3 (pages 20-21).</p> <ul style="list-style-type: none"> • Intensity-modulated radiation therapy (IMRT) <p>Note: You must get prior approval for outpatient IMRT related to cancers other than head, neck, breast, or prostate cancer. Please refer to page 20 for more information.</p> <ul style="list-style-type: none"> • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy <p>Note: Home nursing visits associated with Home IV/infusion therapy are covered as shown under <i>Home health services</i> on page 55.</p> <ul style="list-style-type: none"> • Outpatient cardiac rehabilitation 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>

Treatment therapies - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	Standard Option	Basic Option
<p>Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.</p> <p>Note: See page 56 for our coverage of osteopathic and chiropractic manipulative treatment.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under <i>Organ/tissue transplants</i> in Section 5(b). See also, <i>Other services</i> under <i>You need prior Plan approval for certain services</i> in Section 3 (pages 20-21).</p> <ul style="list-style-type: none"> Renal dialysis – Hemodialysis and peritoneal dialysis Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies] 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
Physical therapy, occupational therapy, speech therapy, and cognitive therapy	Standard Option	Basic Option
<ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician Cognitive rehabilitation therapy when performed by a licensed therapist or physician <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit (No deductible)</p> <p>Preferred specialist: \$30 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p>

Physical therapy, occupational therapy, speech therapy, and cognitive therapy - continued on next page

Benefit Description	You Pay	
Physical therapy, occupational therapy, speech therapy, and cognitive therapy (cont.)	Standard Option	Basic Option
	<p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay</i> • <i>Maintenance or palliative rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Hippotherapy (exercise on horseback)</i> • <i>Services provided by massage therapists</i> 	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	Standard Option	Basic Option
<p>Hearing tests related to illness or injury</p> <p>Note: For our coverage of hearing aids and related services, see page 52.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p>

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	Standard Option	Basic Option
		Participating/Non-participating: You pay all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine hearing tests (except as indicated on page 41) • Hearing aids (except as described on page 52) • Testing and examinations for the prescribing or fitting of hearing aids(except as needed for covered hearing aids described on page 52) 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	Standard Option	Basic Option
<p>Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed:</p> <ul style="list-style-type: none"> • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition • For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 <p>Note: Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 <p>Note: See page 49 for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus.</p> <p>Note: See Section 5(b), <i>Surgical procedures</i>, for coverage for surgical treatment of amblyopia and strabismus.</p> <p>Note: See pages 35-36 in this Section for our payment levels for <i>Lab, X-ray, and other diagnostic tests</i> performed or ordered by your provider. Benefits are not available for refractions except as described on page 49.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment (No deductible)</p> <p>Preferred specialist: \$30 copayment (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> • Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 49 • Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc. • Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom • Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above • LASIK, INTACS, radial keratotomy, and other refractive surgical services • Refractions, including those performed during an eye examination related to a specific medical condition, except as described on page 49 	All charges	All charges
Foot care	Standard Option	Basic Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p> <p>Note: See Section 5(b) for our coverage for surgical procedures.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies)</p> <p>Preferred specialist: \$30 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated on page 45</i></p>	All charges	All charges

Benefit Description	You Pay	
Orthopedic and prosthetic devices	Standard Option	Basic Option
<p>Orthopedic braces and prosthetic appliances such as:</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Surgically implanted penile prostheses to treat erectile dysfunction <p>Note: A prosthetic appliance is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.</p> <p>We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Hearing aids for children up to age 22, limited to \$2,500 per calendar year • Hearing aids for adults age 22 and over, limited to \$2,500 every 3 calendar years <p>Note: Benefits for hearing aid dispensing fees, accessories, supplies, and repair services are included in the benefit limits described above.</p>	Any amount over \$2,500 (No deductible)	Any amount over \$2,500
<ul style="list-style-type: none"> • Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to \$5,000 per calendar year 	Any amount over \$5,000 (No deductible)	Any amount over \$5,000
<ul style="list-style-type: none"> • Wigs for hair loss due to chemotherapy for the treatment of cancer <p>Note: Benefits for wigs are paid at 100% of the billed amount, limited to \$350 for one wig per lifetime.</p>	Any amount over \$350 for one wig per lifetime (No deductible)	Any amount over \$350 for one wig per lifetime
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Shoes and over-the-counter orthotics</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to chemotherapy for the treatment of cancer, as stated on page 46 	All charges	All charges
Durable medical equipment (DME)	Standard Option	Basic Option
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); Are medically necessary; Are primarily and customarily used only for a medical purpose; Are generally useful only to a person with an illness or injury; Are designed for prolonged use; and Serve a specific therapeutic purpose in the treatment of an illness or injury. <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Home dialysis equipment Oxygen equipment Hospital beds Wheelchairs Crutches Walkers Continuous passive motion (CPM) devices Dynamic orthotic cranioplasty (DOC) devices Other items that we determine to be DME, such as compression stockings <p>Note: We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>
<ul style="list-style-type: none"> Speech-generating devices, limited to \$1,250 per calendar year 	Any amount over \$1,250 per year (No deductible)	Any amount over \$1,250 per year
<p><i>Not covered :</i></p> <ul style="list-style-type: none"> Exercise and bathroom equipment Lifts, such as seat, chair, or van lifts Car seats Air conditioners, humidifiers, dehumidifiers, and purifiers Breast pumps, except as described on page 43 	All charges	All charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Communications equipment, devices, and aids (including computer equipment) such as “story boards” or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed on page 53) Equipment for cosmetic purposes Topical Hyperbaric Oxygen Therapy (THBO) 	All charges	All charges
Medical supplies	Standard Option	Basic Option
<ul style="list-style-type: none"> Medical foods for children with inborn errors of amino acid metabolism Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) <p>Note: See Section 10, <i>Definitions</i>, for more information about medical foods.</p> <ul style="list-style-type: none"> Ostomy and catheter supplies Oxygen <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility.</p> <ul style="list-style-type: none"> Blood and blood plasma, except when donated or replaced, and blood plasma expanders <p>Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<i>Not covered: Infant formulas used as a substitute for breastfeeding</i>	All charges	All charges
Home health services	Standard Option	Basic Option
<p>Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when:</p> <ul style="list-style-type: none"> A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and A physician orders the care 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p>	Preferred: \$25 copayment per visit

Home health services - continued on next page

Benefit Description	You Pay	
Home health services (cont.)	Standard Option	Basic Option
	<p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.</p>	<p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient’s family</i> • <i>Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter</i> • <i>Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home, except as included in the benefits described on page 80</i> • <i>Private duty nursing</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Chiropractic	Standard Option	Basic Option
<ul style="list-style-type: none"> • One office visit per calendar year • One set of X-rays per calendar year <p>Note: See page 56 for our coverage of osteopathic and chiropractic manipulative treatment.</p> <p>Note: Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 16 for additional information.</p>	<p>Preferred: \$20 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Office visits and X-rays that you pay for while meeting your calendar year deductible count toward the appropriate benefit limit.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
Manipulative treatment	Standard Option	Basic Option
<p>Manipulative treatment performed by a Doctor of Osteopathy (D.O.), Doctor of Medicine (M.D.), or Doctor of Chiropractic (D.C.) when the provider is practicing within the scope of his/her license, limited to:</p> <ul style="list-style-type: none"> • Osteopathic manipulative treatment to any body region 	<p>Preferred: \$20 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p>	<p>Preferred: \$25 copayment per visit</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 manipulative visits per person, per calendar year.</p>

Manipulative treatment - continued on next page

Benefit Description	You Pay	
Manipulative treatment (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Chiropractic spinal and/or extraspinal manipulative treatment <p>Note: Benefits for manipulative treatment, including treatment performed in a medically underserved area, are limited to the services and combined treatment visits stated here.</p> <p>Note: Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 16 for additional information.</p>	<p>Preferred: \$20 copayment per visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 12 manipulative visits per person, per calendar year.</p> <p>Note: Manipulation visits that you pay for while meeting your calendar year deductible count toward the treatment limit cited above.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 manipulative visits per person, per calendar year.</p> <p>Participating/Non-participating: You pay all charges</p>
Alternative treatments	Standard Option	Basic Option
<p>Acupuncture</p> <p>Note: See page 72 for our coverage of acupuncture when provided as anesthesia for covered surgery.</p> <p>Note: See page 42 for our coverage of acupuncture when provided as anesthesia for covered maternity care.</p> <p>Note: We may also cover services of certain alternative treatment providers in medically underserved areas. See page 16 for additional information.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Acupuncture must be performed and billed by a physician or licensed acupuncturist.</p> <p>Note: Benefits for acupuncture are limited to 24 visits per calendar year.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p>	<p>Preferred primary care physician: \$25 copayment per visit</p> <p>Preferred physician specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Note: Acupuncture must be performed and billed by a physician.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Services you receive from noncovered providers such as: <ul style="list-style-type: none"> Naturopaths 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Alternative treatments - continued on next page

Benefit Description	You Pay	
Alternative treatments (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Hypnotherapists • Biofeedback • Self-care or self-help training 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	Standard Option	Basic Option
<ul style="list-style-type: none"> • Smoking and tobacco cessation treatment • Individual counseling for smoking and tobacco use cessation <p>Note: Benefits are not available for group counseling.</p> <ul style="list-style-type: none"> • Smoking and tobacco cessation classes <p>Note: See Section 5(f) for our coverage of smoking and tobacco cessation drugs.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Diabetic education when billed by a covered provider <p>Note: We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program.</p> <p>Note: See pages 38 and 41 for our coverage of nutritional counseling services that are not part of a diabetic education program.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Marital, family, educational, or other counseling or training services when performed as part of an educational class or program • Premenstrual syndrome (PMS), lactation (except as described on page 42), headache, eating disorder (except as described on pages 38 and 41), and other educational clinics • Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay • Services performed or billed by a school or halfway house or a member of its staff • Applied behavior analysis (ABA) or ABA therapy 	<i>All charges</i>	<i>All charges</i>

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 20 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” to show when the calendar year deductible does not apply.
 - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
 - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 21 for more information.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See below and page 18 for the exceptions to this requirement.**
 - We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no deductible under Basic Option.		
Surgical procedures	Standard Option	Basic Option
<p>A comprehensive range of services provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none">• Operative procedures• Treatment of fractures and dislocations, including casting• Normal pre- and post-operative care by the surgeon• Correction of amblyopia and strabismus• Colonoscopy (with or without biopsy) to diagnose or treat a specific condition <p>Note: See page 38 for our coverage of screening colonoscopies billed for by a physician or other covered health care professional.</p> <ul style="list-style-type: none">• Other endoscopy procedures• Biopsy procedures• Removal of tumors and cysts• Correction of congenital anomalies (see <i>Reconstructive surgery</i> on page 62)• Treatment of burns• Circumcision of newborn• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device.• Voluntary sterilization for men (vasectomy) <p>Note: See page 44 for our coverage of voluntary sterilization procedures for women.</p> <ul style="list-style-type: none">• Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures• Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with one or more co-morbidities; eligible members must be age 18 or over <p>Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on page 60.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 21 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	Standard Option	Basic Option
<p>Note: Prior approval is required for outpatient surgery for morbid obesity. For more information about prior approval, please refer to page 20.</p> <ul style="list-style-type: none"> • Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. The member must meet all requirements. <ul style="list-style-type: none"> - Diagnosis of morbid obesity (as defined on page 59) for a period of 2 years prior to surgery - Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery. (Note: Benefits are not available for commercial weight loss programs; see page 38 for our coverage of nutritional counseling services.) - Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise - Evidence that attempts at weight loss in the 1-year period prior to surgery have been ineffective - Psychological clearance of the member's ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner (see page 90 for our payment levels for mental health services) - Member has not smoked in the 6 months prior to surgery - Member has not been treated for substance abuse for 1 year prior to surgery and there is no evidence of substance abuse during the 1-year period prior to surgery • Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements: <ul style="list-style-type: none"> - All criteria listed above for the initial procedure must be met again - Previous surgery for morbid obesity was at least 2 years prior to repeat procedure - Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure - Member complied with previously prescribed post-operative nutrition and exercise program 		

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Claims for the surgical treatment of morbid obesity must include documentation from the member's provider(s) that all pre-surgical requirements have been met 		
<p>Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure.</p> <p>Note: We do not pay extra for “incidental” procedures (those that do not add time or complexity to patient care).</p> <p>Note: When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Services of a standby physician</i> <i>Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]</i> <i>Cosmetic surgery</i> <i>LASIK, INTACS, radial keratotomy, and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery	Standard Option	Basic Option
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. <p>Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.</p> <p>Note: You must get prior approval for outpatient surgical correction of congenital anomalies. Please refer to page 20 for more information.</p> <ul style="list-style-type: none"> Treatment to restore the mouth to a pre-cancer state All stages of breast reconstruction surgery following a mastectomy, such as: 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 21 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of the patient's breasts - Treatment of any physical complications, such as lymphedemas <p>Note: Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility.</p> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> • Surgery for placement of penile prostheses to treat erectile dysfunction 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 21 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about "agents.")</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)</i> • <i>Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown above</i> 	All charges	All charges
Oral and maxillofacial surgery	Standard Option	Basic Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see <i>Definitions</i>) to jaws, cheeks, lips, tongue, roof and floor of mouth <p>Note: You must get prior approval for outpatient surgery needed to correct accidental injuries as described above. Please refer to page 20 for more information.</p> <ul style="list-style-type: none"> • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Incision and surgical treatment of accessory sinuses, salivary glands, or ducts Reduction of dislocations and excision of temporomandibular joints Removal of impacted teeth <p>Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 21 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g) Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g) Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g) Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g) 	All charges	All charges
Organ/tissue transplants	Standard Option	Basic Option
<p>Solid organ transplants (see list in the next box below) are subject to medical necessity and experimental/ investigational review. Refer to <i>Other services</i> in Section 3 (see page 20) for prior approval procedures.</p> <p>Prior approval requirements:</p> <p>You must obtain prior approval (see page 20) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:</p>		

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Blood or marrow stem cell transplant procedures <p>Note: See pages 68 and 69 for services related to blood or marrow stem cell transplants covered under clinical trials.</p> <ul style="list-style-type: none"> Autologous pancreas islet cell transplant Heart Heart-lung Intestinal transplants (small intestine with or without other organs) Liver Lung (single, double, or lobar) Pancreas Simultaneous liver-kidney Simultaneous pancreas-kidney <p>Note: Refer to page 19 for information about precertification of inpatient care.</p>		
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> Cornea Heart Heart-lung Kidney Liver Pancreas Simultaneous pancreas-kidney Simultaneous liver-kidney Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Single, double, or lobar lung For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 21 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Physicians consider many features to determine how diseases will respond to different types of treatments. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Myeloablative allogeneic blood or marrow stem cell transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic myelogenous leukemia - Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) - High-risk neuroblastoma - Hodgkin's lymphoma - Infantile malignant osteopetrosis - Inherited metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Marrow failure [i.e., severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] - MDS/MPN [e.g., Chronic myelomonocytic leukemia (CMML)] - Myelodysplasia/Myelodysplastic syndromes (MDS) - Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) - Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Primary Immunodeficiencies (e.g., Severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (<i>continued from page 65</i>). For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Myeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan. <ul style="list-style-type: none"> - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan. <ul style="list-style-type: none"> - Acute non-lymphocytic (myelogenous) leukemia/acute lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with poor response to therapy; short time to progression; transformed disease; or high risk disease - Chronic myelogenous leukemia - Hemoglobinopathy (Sickle-cell anemia, Thalassemia major) - Hodgkin's lymphoma - Infantile malignant osteopetrosis 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Inherited Metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Marrow failure (severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia) - MDS/MPN [e.g., chronic myelomonocytic leukemia (CMML)] - Myelodysplasia/myelodysplastic syndromes (MDS) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (<i>continued from page 66</i>). For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan (<i>continued from page 66</i>). - Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) - Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] - Primary Immunodeficiencies (Severe combined immunodeficiency, Wiskott-Aldrich syndrome, Hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies) • Autologous blood or marrow stem cell transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Central Nervous System (CNS) Embryonal tumors [e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma] - Ewing's sarcoma - Germ cell tumors - High-risk neuroblastoma - Hodgkin's lymphoma - Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>1. For the following blood or marrow stem cell transplant procedures, we provide benefits only when conducted at a Cancer Research Facility, a Blue Distinction Centers for Transplants facility, or a Foundation for the Accreditation of Cellular Therapy (FACT) accredited facility (see pages 17 and 18) and only when performed as part of a clinical trial that meets the requirements listed on page 69:</p> <ul style="list-style-type: none"> • Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants for: <ul style="list-style-type: none"> - Breast cancer - Colon cancer - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Epidermolysis bullosa - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Retinoblastoma - Rhabdomyosarcoma - Sarcoma - Wilm's Tumor 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Autologous blood or marrow stem cell transplants for: Note: If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the requirements shown on page 69 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available. Breast cancer Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) Chronic myelogenous leukemia Epithelial ovarian cancer Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) Retinoblastoma Rhabdomyosarcoma Wilm's Tumor 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>2. For the following procedures, we provide benefits only when conducted at a FACT-accredited facility (see page 18) and only when performed as part of a clinical trial that meets the requirements listed below:</p> <ul style="list-style-type: none"> Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants or autologous blood or marrow stem cell transplants for: <ul style="list-style-type: none"> Autoimmune disease (e.g., Multiple sclerosis, Scleroderma, Systemic lupus erythematosus, Chronic inflammatory demyelinating polyneuropathy) 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>3. Requirements for blood or marrow stem cell transplants covered under clinical trials:</p> <p>For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials:</p> <ul style="list-style-type: none"> You must contact us at the customer service number listed on the back of your ID card to obtain prior approval (see page 20); The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility where the procedure is to be delivered; and The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. 		

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<p>Note: Clinical trials are research studies in which physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. A clinical trial has possible benefits as well as risks. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial. Information regarding clinical trials is available at www.cancer.gov.</p> <p>Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Cancer Research Facility or FACT-accredited facility to treat your condition at the time you seek to be included in a clinical trial. If your physician has recommended you participate in a clinical trial, we encourage you to contact the Case Management Department at your Local Plan for assistance.</p> <p>Note: See page 129 for our coverage of other costs associated with clinical trials.</p>		
<p>Related transplant services:</p> <ul style="list-style-type: none"> Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 65-69 <p>Note: Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells.</p> <ul style="list-style-type: none"> Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 65-69 Related medical and hospital expenses of the donor, when we cover the the recipient 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Related services or supplies provided to the recipient Donor screening tests for up to three non-full sibling (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for transplant <p>Note: See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$150 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/Tissue Transplants at Blue Distinction Centers for Transplants®

We participate in the Blue Distinction Centers for Transplants program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility (see page 17 for more information).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services.

You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous pancreas-kidney
- Single or double lung
- Blood or marrow stem cell transplants listed on pages 65-68
- Related transplant services listed on page 70

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 64 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 17).

Note: See pages 65-69 for requirements related to blood or marrow stem cell transplant coverage.

Note: See page 17 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants for any diagnosis not listed as covered</i> • <i>Donor screening tests and donor search expenses, except as defined on page 70</i> • <i>Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Anesthesia	Standard Option	Basic Option
<p>Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by:</p> <ul style="list-style-type: none"> • A certified registered nurse anesthetist (CRNA), or • A physician other than the physician (or the assistant) performing the covered medical or surgical procedure <p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness.</p> <p>Note: See Section 5(c) for our payment levels for anesthesia services billed by a facility.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- **Note: Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 77. See page 139 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 20 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible of \$350 per person (\$700 per family) applies to only a few benefits in this Section. Unlike in Sections 5(a) and 5(b), we added “(calendar year deductible applies)” when it applies
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See page 18 for the exceptions to this requirement.**

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.		
Inpatient hospital	Standard Option	Basic Option
<p>Room and board, such as:</p> <ul style="list-style-type: none">• Semiprivate or intensive care accommodations• General nursing care• Meals and special diets <p>Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 140 for more information.</p>	<p>Preferred: \$250 per admission copayment for unlimited days</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment</p> <p>Note: If you are admitted to a Member or Non-member facility due to a medical emergency or accidental injury, you pay a \$350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none">• Operating, recovery, maternity, and other treatment rooms• Prescribed drugs• Diagnostic studies, radiology services, laboratory tests, and pathology services• Administration of blood or blood plasma• Dressings, splints, casts, and sterile tray services• Internal prosthetic devices• Other medical supplies and equipment, including oxygen• Anesthetics and anesthesia services• Take-home items• Pre-admission testing recognized as part of the hospital admissions process• Nutritional counseling• Acute inpatient rehabilitation <p>Note: Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 77. See page 139 for more information about these types of services.</p> <p>Note: Here are some things to keep in mind:</p>	<p>Preferred: \$250 per admission copayment for unlimited days</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility.</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Note: For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to \$150 per admission.</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). <p>Note: See pages 42-43 for other covered maternity services.</p> <p>Note: See page 54 for coverage of blood and blood products.</p>	<p>Preferred: \$250 per admission copayment for unlimited days</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility.</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Note: For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to \$150 per admission.</p> <p>Member/Non-member: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers</i> <i>Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services</i> <i>Private duty nursing</i> <p><i>Hospital room and board expenses when, in our judgement, a hospital admission or portion of an admission is:</i></p> <ul style="list-style-type: none"> <i>Custodial or long term care</i> <i>Convalescent care or a rest cure</i> <i>Domiciliary care provided because care in the home is not available or is unsuitable</i> <i>Not medically necessary, such as when services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office) - Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office) <p>Note: If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers (see pages 16-18).</p>	All charges	All charges
Outpatient hospital or ambulatory surgical center	Standard Option	Basic Option
<p>Outpatient surgical, diagnostic, and treatment services performed and billed by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Observation services <p>Note: Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on this page. See page 139 for more information about these types of services.</p> <ul style="list-style-type: none"> • Diagnostic bone density tests • CT scans/MRIs/PET scans • Diagnostic angiography • Diagnostic genetic testing <p>Note: Genetic screening is not covered.</p> <ul style="list-style-type: none"> • Nuclear medicine • Sleep studies • Chemotherapy and radiation therapy • Colonoscopy (with or without biopsy) to diagnose or treat a specific condition 	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$100 copayment per day per facility (except as noted below)</p> <p>Member/Non-member: You pay all charges (except for diagnostic studies and radiological services as noted below)</p> <p>Note: You pay a \$100 copayment per day per facility for the diagnostic studies and radiological services listed here, when billed for by a Member or Non-member facility. For services provided at a Non-member facility, you also pay any difference between our allowance and the billed amount.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 136 for more information about "agents.")</p>

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	Standard Option	Basic Option
<p>Note: See page 38 for our coverage of screening colonoscopies.</p> <ul style="list-style-type: none"> • Intravenous (IV)/infusion therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency diagnostic and/or treatment services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Facility supplies for hemophilia home care • Other medical supplies, including oxygen <p>Note: See pages 85-88 for our payment levels for care related to a medical emergency or accidental injury.</p> <p>Note: See pages 44-45 for our coverage of family planning services.</p>	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$100 copayment per day per facility (except as noted below)</p> <p>Member/Non-member: You pay all charges (except for diagnostic studies and radiological services as noted below)</p> <p>Note: You pay a \$100 copayment per day per facility for the diagnostic studies and radiological services listed here, when billed for by a Member or Non-member facility. For services provided at a Non-member facility, you also pay any difference between our allowance and the billed amount.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p>
<p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p> <p>See pages 42-44 for other included maternity services.</p> <p>Note: See page 79 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility.</p> <p>Note: We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries.</p> <p>We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), <i>Dental benefits</i>, for additional benefit information.</p>		
<p>Outpatient diagnostic and treatment services performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <ul style="list-style-type: none"> • EEGs 	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p>	<p>Preferred: \$25 copayment per day per facility</p>

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> • Ultrasounds • X-rays (including set-up of portable X-ray equipment) • Cardiac rehabilitation • Cognitive rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p>	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: See page 48 for our coverage of physical, occupational, and speech therapy.</p>	<p>Preferred: \$25 copayment per day per facility</p> <p>Note: You may be responsible for paying a \$100 copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.</p> <p>Member/Non-member: You pay all charges (except as noted below)</p> <p>Note: You pay a \$25 copayment per day per facility for EEGs, ultrasounds, and X-rays billed for by a Member or Non-member facility. For services provided at a Non-member facility, you also pay any difference between our allowance and the billed amount.</p> <p>Note: Benefits are limited to a total of 50 visits per person, per calendar year for outpatient physical, occupational, or speech therapy, or a combination of all three, regardless of the type of covered provider billing for the services.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p>
<p>Outpatient diagnostic and treatment services performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <ul style="list-style-type: none"> • Laboratory tests and pathology services • EKGs <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p>	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (calendar year deductible applies)</p>	<p>Preferred: Nothing</p> <p>Member: Nothing</p> <p>Non-member: You pay any difference between our allowance and the billed amount</p>

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	Standard Option	Basic Option
	Non-member facilities: 35% of the Plan allowance (calendar year deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	<p>Note: You may be responsible for paying a \$100 copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 136 for more information about “agents.”)</p>
<p>Outpatient adult preventive care performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <ul style="list-style-type: none"> • Routine adult physical examinations and screening procedures described on pages 37-38 • Cancer screenings listed on page 38 and ultrasound screening for aortic abdominal aneurysm <p>Note: See page 41 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.</p>	See pages 37-39 for our payment levels for covered preventive care services for adults.	<p>Preferred: Nothing</p> <p>Note: See page 39 for our payment levels for routine adult immunizations.</p> <p>Member/Non-member: Nothing for cancer screenings and ultrasound screening for aortic abdominal aneurysm</p> <p>Note: Benefits are not available for routine adult physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p>
<p>Outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p>	<p>Preferred facilities: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Member/Non-member facilities: 35% of the Plan allowance (calendar year deductible applies)</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Note: You may also be responsible for paying a copayment per day per facility for outpatient services. See above and pages 77-78 for specific coverage information.</p> <p>Member/Non-member: You pay all charges</p>

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits	Standard Option	Basic Option
<p>Limited to the following benefits for Medicare Part A copayments:</p> <p>When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, Standard Option provides limited secondary benefits.</p> <p>We pay the applicable Medicare Part A copayments incurred in full during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases.</p> <p>If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day.</p> <p>Note: See page 48 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs.</p> <p>Note: If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.</p>	<p>Preferred: Nothing</p> <p>Participating/Member: Nothing</p> <p>Non-participating/Non-member: Nothing</p> <p>Note: You pay all charges not paid by Medicare after the 30th day.</p>	<p><i>All charges</i></p>
Hospice care	Standard Option	Basic Option
<p>Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six (6) months or less due to a terminal medical condition, as certified by the member's primary care provider or specialist.</p>	<p>See below and pages 82-83</p>	<p>See below and pages 82-83</p>
<p>Pre-Hospice Enrollment Benefits</p> <p>Prior approval is not required.</p> <p>Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as:</p> <ul style="list-style-type: none"> Evaluating the member's need for pain and/or symptom management; and 	<p>Nothing</p>	<p>Nothing</p>

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Counseling regarding hospice and other care options 	Nothing	Nothing
<p>Prior approval from the Local Plan is required for all hospice services. Our prior approval decision will be based on the medical necessity of the hospice treatment plan and the clinical information provided to us by the primary care provider (or specialist) and the hospice provider. We may also request information from other providers who have treated the member. All hospice services must be billed by the approved hospice agency. You are responsible for making sure the hospice care provider has received prior approval from the Local Plan (see page 20 for instructions). Please check with your Local Plan and/or go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, for listings of Preferred hospice providers.</p> <p>Note: If Medicare Part A is the primary payor for the member's hospice care, prior approval is not required. However, our benefits will be limited to those services listed above and on pages 82 and 83.</p> <p>Members with a terminal medical condition (or those acting on behalf of the member) are encouraged to contact the Case Management Department at their Local Plan for information about hospice services and Preferred hospice providers.</p>		
<p>Covered services</p> <p>We provide benefits for the hospice services listed below when the services have been included in an approved hospice treatment plan and are provided by the home hospice program in which the member is enrolled:</p> <ul style="list-style-type: none"> Nursing care Periodic physician visits Dietary counseling Durable medical equipment rental Medical social services Medical supplies Oxygen therapy Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition Prescription drugs 	See below	See below

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency) 	See below	See below
<p>Traditional Home Hospice Care</p> <p>Periodic visits to the member's home for the management of the terminal medical condition and to provide limited patient care in the home. See page 81 for prior approval requirements.</p>	Nothing	Nothing
<p>Continuous Home Hospice Care</p> <p>Services provided in the home to members enrolled in home hospice during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member's condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).</p> <p>Note: Members must receive prior approval from the Local Plan for each episode of continuous home hospice care (see page 81). An episode consists of up to seven (7) consecutive days of continuous care. Each episode must be separated by at least 21 days of traditional home hospice care. The member must be enrolled in a home hospice program and the continuous home hospice care services must be provided by the home hospice program in which the member is enrolled.</p>	<p>Preferred: \$250 per episode copayment</p> <p>Member: \$350 per episode copayment</p> <p>Non-member: \$350 per episode copayment, plus 35% of the Plan allowance and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 maximum per episode</p> <p>Member/Non-member: You pay all charges</p>
<p>Inpatient Hospice Care</p> <p>Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when:</p> <ul style="list-style-type: none"> Inpatient services are necessary to control pain and/or manage the member's symptoms; Death is imminent; or Inpatient services are necessary to provide an interval of relief (respite) to the caregiver <p>Note: Benefits are provided for up to thirty (30) consecutive days in a facility licensed as an inpatient hospice facility. Each inpatient stay must be separated by at least 21 days of traditional home hospice care. The member does not have to be enrolled in a home hospice care program to be eligible for the first inpatient stay. However, the member must be enrolled in a home hospice care program in order to receive benefits for subsequent inpatient stays.</p>	<p>Preferred: Nothing</p> <p>Member: \$350 per admission copayment), plus 35% of the Plan allowance</p> <p>Non-member: \$350 per admission copayment plus 35% of the Plan allowance, and any remaining balance after our payment</p>	<p>Preferred: Nothing</p> <p>Member/Non-member: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Homemaker services</i> 	<i>All charges</i>	<i>All charges</i>

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency 	All charges	All charges
Ambulance	Standard Option	Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> Associated with covered hospital inpatient care Related to medical emergency Associated with covered hospice care <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p> <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member or Non-participating/Non-member: Nothing (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> Wheelchair van services and gurney van services Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care 	All charges	All charges

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person’s health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option does not apply. There is no calendar year deductible under Basic Option.		
Accidental injury	Standard Option	Basic Option
<ul style="list-style-type: none">• Physician services in the hospital outpatient department, urgent care center, or physician’s office, including diagnostic studies, radiology services, laboratory tests, and pathology services• Related outpatient hospital services and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services <p>Note: We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: See Section 5(g) for dental benefits for accidental injuries.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member: Nothing (No deductible)</p> <p>Participating/Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p> <p>Note: For drugs, services, supplies, and/or durable medical equipment billed by a provider other than a hospital, urgent care center, or physician, see Sections 5(a) and 5(f) for the benefit levels that apply.</p>	<p>Preferred urgent care center: \$50 copayment per visit</p> <p>Participating/Non-participating urgent care center: You pay all charges</p> <p>Preferred emergency room: \$125 copayment per visit</p> <p>Participating/Member emergency room: \$125 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$125 copayment per visit, plus any difference between our allowance and the billed amount</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$125 emergency room copayment. However, the \$150 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p> <p>Note: Regular benefit levels apply to covered services provided in settings other than an emergency room or urgent care center. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none">• Oral surgery except as shown in Section 5(b)• Injury to the teeth while eating• Emergency room professional charges for shift differentials	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
Medical emergency	Standard Option	Basic Option
<ul style="list-style-type: none"> • Physician services including diagnostic studies, radiology services, laboratory tests, and pathology services • Related outpatient hospital services and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services <p>Note: We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: Please refer to Section 3 for information about precertifying emergency hospital admissions.</p> <p>Note: Regular benefit levels apply to covered services provided in settings other than an emergency room or urgent care center. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p>	<p>Preferred urgent care center: \$40 copayment per visit (No deductible)</p> <p>Participating urgent care center: 35% of the Plan allowance</p> <p>Non-participating urgent care center: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Preferred emergency room: 15% of the Plan allowance</p> <p>Participating/Member emergency room: 15% of the Plan allowance</p> <p>Non-participating/Non-member emergency room: 15% of the Plan allowance. If you use a Non-participating provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: These benefit levels do not apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on page 86 for the benefits we provide.</p>	<p>Preferred urgent care center: \$50 copayment per visit</p> <p>Participating/Non-participating urgent care center: You pay all charges</p> <p>Preferred emergency room: \$125 copayment per visit</p> <p>Participating/Member emergency room: \$125 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$125 copayment per visit, plus any difference between our allowance and the billed amount</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$125 emergency room copayment. However, the \$150 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>
<i>Not covered: Emergency room professional charges for shift differentials</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	Standard Option	Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p> <p>Note: See Section 5(c) for non-emergency ambulance services.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services (No deductible)</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services (No deductible)</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>

Ambulance - continued on next page

Benefit Description	You pay	
Ambulance (cont.)	Standard Option	Basic Option
	Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day (No deductible).	
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p> <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member or Non-participating/Non-member: Nothing (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Wheelchair van services and gurney van services</i> • <i>Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you have a chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to pages 115 and 116. Contact us at the telephone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your health care needs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added “(No deductible)” to show when the deductible does not apply.
 - You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
 - **You must use Preferred providers in order to receive benefits. See page 18 for the exceptions to this requirement.**
 - There is **no calendar year deductible.**

Benefit Description		You Pay
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Professional services	Standard Option	Basic Option
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional services, including individual or group therapy, provided by licensed professional mental health and substance abuse practitioners when acting within the scope of their license	Preferred: \$20 copayment for the visit (No deductible)	Preferred: \$25 copayment per visit
<ul style="list-style-type: none"> • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Pharmacotherapy (medication management) • Psychological testing 	Participating: 35% of the Plan allowance Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount	Participating/Non-participating: You pay all charges

Benefit Description	You Pay	
Professional services (cont.)	Standard Option	Basic Option
<p>Note: To locate a Preferred provider, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.</p> <p>Note: See page 57 for our coverage of smoking and tobacco cessation treatment.</p> <p>Note: See page 42 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy.</p>	<p>Preferred: \$20 copayment for the visit (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> Inpatient professional visits 	<p>Preferred: Nothing (No deductible)</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> Professional charges for facility-based intensive outpatient treatment Professional charges for outpatient diagnostic tests 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> Professional charges for intensive outpatient treatment in a provider's office or other professional setting 	<p>Preferred: 15% of the Plan allowance</p> <p>Participating: 35% of the Plan allowance</p> <p>Non-participating: 35% of the Plan allowance, plus the difference between our allowance and the billed amount</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>

Benefit Description	You Pay	
Inpatient hospital or other covered facility	Standard Option	Basic Option
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Diagnostic tests <p>Note: Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a hospital/treatment facility (excluding a residential treatment center) for rehabilitative treatment of alcoholism or substance abuse.</p> <p>Note: A residential treatment center is not a covered hospital/treatment facility. See Section 10, <i>Definitions</i>, for more information.</p> <p>Note: You must get precertification of inpatient hospital stays; failure to do so will result in a \$500 penalty.</p>	<p>Preferred: \$250 per admission copayment for unlimited days (No deductible)</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (No deductible)</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance, and any remaining balance after our payment (No deductible)</p>	<p>Preferred: \$150 per day copayment up to \$750 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>
Outpatient hospital or other covered facility	Standard Option	Basic Option
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Diagnostic tests Psychological testing Partial hospitalization Facility-based intensive outpatient treatment <p>Note: A residential treatment center is not a covered hospital/treatment facility. See Section 10, <i>Definitions</i>, for more information.</p>	<p>Preferred: 15% of the Plan allowance</p> <p>Member: 35% of the Plan allowance</p> <p>Non-member: 35% of the Plan allowance. You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$25 copayment per day per facility</p> <p>Member/Non-member: You pay all charges (except as noted below)</p> <p>Note: For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing.</p>
Not covered (Inpatient or Outpatient)	Standard Option	Basic Option
<ul style="list-style-type: none"> Marital, family, educational, or other counseling or training services Services performed by a noncovered provider Testing and treatment for learning disabilities and mental retardation Applied behavior analysis (ABA) or ABA therapy Services performed or billed by residential treatment centers, schools, halfway houses, or members of their staffs <p>Note: We cover professional services as described on pages 89 and 90 when they are provided and billed by a covered professional provider acting within the scope of his or her license.</p>	All charges	All charges

Not covered (Inpatient or Outpatient) - continued on next page

Benefit Description	You Pay	
Not covered (Inpatient or Outpatient) (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> • <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present</i> • <i>Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)</i> • <i>Light boxes</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 96.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 105 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 105 of this Section for more information about this important program.
- We may reclassify a Tier 2 preferred brand-name drug as a Tier 3 non-preferred brand-name drug when a generic equivalent becomes available. If your brand-name drug is reclassified as Tier 3, your cost-share will increase.
- **Under Standard Option,**
 - You may use the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program to fill your prescriptions.
 - The calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. We added “(calendar year deductible applies)” when it applies.
 - PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option,**
 - **You must use Preferred providers or the Specialty Drug Pharmacy Program in order to receive benefits. See page 18 for the exceptions to this requirement.** Our specialty drug pharmacy is a Preferred provider.
 - There is **no calendar year deductible.**
 - The Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, through a Non-preferred internet pharmacy, through our Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, our Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. See page 143 for the definition of “specialty drugs.”

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy, through a Preferred internet pharmacy, or through the Specialty Drug Pharmacy Program, in order to receive benefits. See page 143 for the definition of “specialty drugs.”

Note: Due to manufacturer restrictions, a small number of specialty drugs used to treat rare or uncommon conditions may be available only through a Preferred retail pharmacy. See page 102 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **We use an open formulary.** This includes a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our preferred drug list.

Under Standard Option, we may ask your doctor to substitute a preferred drug in order to help control costs. If you purchase a drug that is not on our preferred drug list, your cost will be higher. We cover drugs that require a prescription (whether or not they are on our preferred drug list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our preferred drug list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our preferred drug list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our preferred drug list.)

Note: Before filling your prescription, please check the preferred/non-preferred status of your medication. Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year.

Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, we work with our Pharmacy and Therapeutics Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in, the Blue Cross and Blue Shield Service Benefit Plan. The Committee meets quarterly to review new and existing drugs, to assist us in our assessment of these drugs for safety and efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. The Committee's recommendations, together with our evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

- Tier 1: Includes generic drugs
- Tier 2: Includes preferred brand-name drugs
- Tier 3: Includes non-preferred brand-name drugs
- Tier 4: Includes specialty drugs

You can view our formulary which includes the preferred drug list on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). If you do not find your drug on the formulary or the preferred drug list, please call 1-800-624-5060. Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

Generic equivalent drugs have the same active ingredients as their brand-name equivalents. By filling your prescriptions (or those of family members covered by the Plan) at a retail pharmacy, through an internet pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug. Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.**

- **Why use generic drugs?** Generic drugs are generally lower cost drugs. Generic drugs have the same quality and strength as brand-name drugs and must meet the same strict standards for quality and effectiveness set by the U.S. Food and Drug Administration (FDA), as brand-name drugs.

You can save money by using generic drugs. Keep in mind that doctors often have several medication options to treat their patients. If your brand-name drug does not have an equivalent generic drug, there may be a generic alternative drug available to treat your condition. You may want to talk with your doctor about generic drugs and how you can reduce your prescription drug costs. You or your doctor may request a brand-name drug even if a generic option is available. See Section 10, *Definitions*, for more information about generic alternatives and generic equivalents

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.
- **These are the dispensing limitations.**

Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail or Specialty Drug Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used.** Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

• **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Standard Option Generic Incentive Program

Your cost-share will be waived for the first 4 generic prescriptions filled (and/or refills ordered) per drug per calendar year if you purchase a brand-name drug listed below while a member of the Service Benefit Plan and then change to a corresponding generic drug replacement while still a member of the Plan.

Preferred Retail Pharmacy

- Your 20% coinsurance amount (15% when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 coinsurance waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for your coinsurance amount.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

Mail Service Prescription Drug Program

- Your \$15 copayment (\$10 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 copayment waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for the copayment.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

If you take one of these brand name drugs...	And change to one of these generic drug replacements...	
Actonel, Boniva, Fosamax	alendronate or ibandronate	*
Aciphex, Dexilant (formerly Kapidex), Nexium, Prevacid, Prilosec, Protonix, Zegerid	omeprazole, lansoprazole, or pantoprazole	*
Ambien CR, Lunesta, Rozerem	zaleplon, zolpidem, or zolpidem extended-release	*
Advicor, Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, Simcor, Vytorin, Zocor	simvastatin, pravastatin, lovastatin, atorvastatin, or fluvastatin	*
Caduet	simvastatin, pravastatin, lovastatin, atorvastatin, fluvastatin, amlodipine or amlodipine/atorvastatin	*
Famvir	famciclovir	*
Valtrex	valacyclovir	*
Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, Teveten	losartan or eprosartan	*
Atacand HCT, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Teveten HCT	losartan HCTZ or eprosartan HCTZ	*
Detrol, Oxytrol, Sanctura, Toviaz, Vesicare	oxybutynin, oxybutynin extended-release, or trospium	*
Detrol LA, Enablex, Sanctura XR	oxybutynin extended-release	*
Betimol, Istalol, Timoptic-XE, Optipranolol	timolol maleate ophthalmic	*

***You will receive your first 4 prescription fills (or refills) of the corresponding generic drug at no charge. (Please see the Standard Option Generic Incentive Program description above for complete information.)**

Please note the list of eligible generic drug replacements may change if additional generic drugs corresponding to the listed brand-name drugs become available during the year. For the most up-to-date information, please visit our Retail Pharmacy Program Web site through www.fepblue.org.

Benefits Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.		
Covered medications and supplies	Standard Option	Basic Option
<ul style="list-style-type: none">Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase <p>Note: See page 96 for our coverage of medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: See Section 5(a), page 54, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.</p> <ul style="list-style-type: none">Insulin and diabetic test stripsNeedles and disposable syringes for the administration of covered medicationsClotting factors and anti-inhibitor complexes for the treatment of hemophiliaDrugs to aid smoking and tobacco cessation that require a prescription by Federal law <p>Note: We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 103.</p> <p>Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 103 for more information.</p> <ul style="list-style-type: none">Contraceptive drugs and devices, limited to:<ul style="list-style-type: none">Diaphragms and contraceptive ringsInjectable contraceptivesIntrauterine devices (IUDs)Implantable contraceptivesOral and transdermal contraceptives <p>Note: We waive your cost-share for generic contraceptive drugs and devices when you purchase them at a Preferred retail or internet pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. See pages 100 and 101 for details.</p> <ul style="list-style-type: none">Drugs for the diagnosis and treatment of infertility, except as described on page 106	See page 96 and pages 98-102	See page 96 and pages 98-102
<ul style="list-style-type: none">Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to:<ul style="list-style-type: none">Emergency contraceptive pillsFemale condomsSpermicidesSponges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Benefits Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<p>Note: We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet FDA standards for OTC products. To receive benefits, you must use a Preferred retail pharmacy and present the pharmacist with a written prescription from your physician.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>
<p>Routine immunizations when provided by a Preferred retail pharmacy that participates in our vaccine network (see below) and administered in compliance with applicable state law and pharmacy certification requirements, limited to:</p> <ul style="list-style-type: none"> • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines • Influenza (flu) vaccines • Pneumococcal vaccines • Meningococcal vaccines <p>Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more of the routine immunizations listed above. Check with your pharmacy or call our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) to see which vaccines your pharmacy can provide.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges (except as noted below)</p> <p>Note: You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges (except as noted below)</p> <p>Note: You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.</p>
<p>Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), limited to:</p> <ul style="list-style-type: none"> • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women capable of pregnancy • Aspirin for men age 45 through 79 and women age 55 through 79 <p>Note: Benefits are not available for <i>Tylenol</i>, <i>Ibuprofen</i>, <i>Aleve</i>, etc.</p> <p>Note: Benefits for the medicines listed above are subject to the dispensing limitations described on page 95 and are limited to recommended prescribed limits.</p> <p>Note: To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<p>Note: A complete list of the preventive care services recommended under the Affordable Care Act is available online at: www.healthcare.gov/law/about/provisions/services/lists.html. Services recommended under the Act and guidelines for health plan coverage are subject to Federal regulations.</p> <p>Note: See page 103 for our coverage of smoking and tobacco cessation medicines.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>
<p>Here is how to obtain your prescription drugs and supplies:</p> <p>Preferred Retail Pharmacies</p> <ul style="list-style-type: none"> • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, <p>or</p> <ul style="list-style-type: none"> • Visit our Web site, www.fepblue.org, select the “Pharmacy” page, and click on the “Retail Pharmacy” link for your enrollment option (Standard or Basic) to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org <p>Note: Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies.</p> <p>Note: For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for drugs obtained from a retail or internet pharmacy, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to page 101.</p> <p>Note: For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077).</p> <p>Note: For coordination of benefits purposes, if you need a statement of Preferred retail/internet pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.</p>	<p>Tier 1 (generic drug): 20% of the Plan allowance</p> <p>Note: You pay 15% of the Plan allowance when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 96 for complete information.</p> <p>Tier 2 (preferred brand-name drug): 30% of the Plan allowance</p> <p>Tier 3 (non-preferred brand-name drug): 45% of the Plan allowance</p> <p>Tier 4 (specialty drug): 30% of the Plan allowance</p> <p>Note: If you use the Specialty Drug Pharmacy Program, you pay an \$80 copayment for the first 30 specialty prescriptions filled (and/or refills ordered) per calendar year; and \$50 per prescription/refill thereafter. See page 102 for more information.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name coinsurance amount when you receive a brand-name drug.</p> <p>Note: When a generic equivalent becomes available, we may classify the Tier 2 brand-name drug as a Tier 3 brand-name drug in determining how much you pay for the drug.</p>	<p>First-time purchase of a new prescription up to a 34-day supply:</p> <p>Tier 1 (generic drug): \$10 copayment</p> <p>Tier 2 (preferred brand-name drug): \$40 copayment</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$50 minimum)</p> <p>Tier 4 (specialty drug): \$50 copayment</p> <p>Refills or continuing prescriptions up to a 90-day supply:</p> <p>Tier 1 (generic drug): \$10 copayment for each purchase of up to a 34-day supply (\$30 copayment for 90-day supply)</p> <p>Tier 2 (preferred brand-name drug): \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply)</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$50 minimum for each purchase of up to a 34-day supply, or \$150 minimum for 90-day supply)</p> <p>Tier 4 (specialty drug): \$50 copayment for each purchase of up to a 34-day supply (\$150 copayment for 90-day supply)</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<p>Note: We waive your cost-share for available forms of generic contraceptive drugs and devices purchased at a Preferred retail or internet pharmacy.</p>	<p>Tier 1 (generic drug): 20% of the Plan allowance</p> <p>Note: You pay 15% of the Plan allowance when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 96 for complete information.</p> <p>Tier 2 (preferred brand-name drug): 30% of the Plan allowance</p> <p>Tier 3 (non-preferred brand-name drug): 45% of the Plan allowance</p> <p>Tier 4 (specialty drug): 30% of the Plan allowance</p> <p>Note: If you use the Specialty Drug Pharmacy Program, you pay an \$80 copayment for the first 30 specialty prescriptions filled (and/or refills ordered) per calendar year; and \$50 per prescription/refill thereafter. See page 102 for more information.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name coinsurance amount when you receive a brand-name drug.</p> <p>Note: When a generic equivalent becomes available, we may classify the Tier 2 brand-name drug as a Tier 3 brand-name drug in determining how much you pay for the drug.</p>	<p>First-time purchase of a new prescription up to a 34-day supply:</p> <p>Tier 1 (generic drug): \$10 copayment</p> <p>Tier 2 (preferred brand-name drug): \$40 copayment</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$50 minimum)</p> <p>Tier 4 (specialty drug): \$50 copayment</p> <p>Refills or continuing prescriptions up to a 90-day supply:</p> <p>Tier 1 (generic drug): \$10 copayment for each purchase of up to a 34-day supply (\$30 copayment for 90-day supply)</p> <p>Tier 2 (preferred brand-name drug): \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply)</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$50 minimum for each purchase of up to a 34-day supply, or \$150 minimum for 90-day supply)</p> <p>Tier 4 (specialty drug): \$50 copayment for each purchase of up to a 34-day supply (\$150 copayment for 90-day supply)</p> <p>Note: If you use the Specialty Drug Pharmacy Program, you pay a \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply). See page 102 for more information.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug.</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
		<p>Note: When a generic equivalent becomes available, we may classify the Tier 2 brand-name drug as a Tier 3 brand-name drug in determining how much you pay for the drug.</p> <p>Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.</p>

Benefit Description	You Pay	
Covered medications and supplies	Standard Option	Basic Option
<p>Non-preferred Retail/Internet Pharmacies</p>	<p>45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount</p> <p>Note: If you use a Non-preferred retail or internet pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>	<p><i>All charges</i></p>
<p>Mail Service Prescription Drug Program</p> <p>Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills.</p> <p>Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program.</p> <p>Note: Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program. (However, the Specialty Drug Pharmacy Program delivers your covered specialty medication directly to you or your doctor's office. See page 102 for more information.)</p> <p>Note: When you use a retail pharmacy or our specialty drug pharmacy to purchase a drug that is not available through the Mail Service Program, you pay the applicable retail or specialty pharmacy cost-share amount. (See above and page 100 for retail pharmacy purchases and page 102 for specialty drug pharmacy purchases.)</p>	<p>Mail Service Program:</p> <p>Tier 1 (generic drug): \$15 copayment</p> <p>Note: You pay a \$10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 96 for complete information.</p> <p>Tier 2 (preferred brand-name drug): \$70 copayment</p> <p>Tier 3 (non-preferred brand-name drug): \$95 copayment</p>	<p>No benefit</p> <p>Note: You may request home delivery of your internet prescription drug purchases. See page 100 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.</p> <p>Note: The Specialty Drug Pharmacy Program delivers specialty medications directly to you or your doctor's office. See page 102 for more information about this program.</p>

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<p>Note: We waive your cost-share for available forms of generic contraceptive drugs and devices purchased through the Mail Service Prescription Drug Program.</p>	<p>Mail Service Program:</p> <p>Tier 1 (generic drug): \$15 copayment</p> <p>Note: You pay a \$10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 96 for complete information.</p> <p>Tier 2 (preferred brand-name drug): \$70 copayment</p> <p>Tier 3 (non-preferred brand-name drug): \$95 copayment</p> <p>Note: The copayment amounts listed above for brand-name drugs only apply to your first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; you pay a \$50 copayment per brand-name prescription/refill thereafter.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.</p>	<p>No benefit</p> <p>Note: You may request home delivery of your internet prescription drug purchases. See page 100 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.</p> <p>Note: The Specialty Drug Pharmacy Program delivers specialty medications directly to you or your doctor's office. See page 102 for more information about this program.</p>

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
	<p>Note: When a generic equivalent becomes available, we may classify the Tier 2 brand-name drug as a Tier 3 brand-name drug in determining how much you pay for the drug.</p>	
<p>Specialty Drug Pharmacy Program</p> <p>We cover specialty drugs that are listed on the Service Benefit Plan Specialty Drug List. (See page 143 for the definition of “specialty drugs.”)</p> <p>If your doctor orders more than a 21-day supply of covered specialty drugs, up to a 90-day supply, you can use this service for your prescriptions and refills.</p> <p>Note: If your specialty drug order is for 21 days or less, please call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549) for assistance.</p> <p>Please refer to Section 7 for instructions on using the Specialty Drug Pharmacy Program.</p> <p>Please note the list of covered specialty drugs is subject to change. For the most up-to-date listing, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our Web site, www.fepblue.org.</p> <p>Note: Due to manufacturer restrictions, a small number of specialty drugs may only be available through a Preferred retail pharmacy. You will be responsible for paying only the copayments shown here for specialty drugs affected by these restrictions.</p>	<p>Specialty Drug Pharmacy Program:</p> <p>Tier 4 (specialty drug): \$80 copayment for the first 30 prescriptions filled (and/or refills ordered) per calendar year; \$50 copayment per prescription/refill thereafter</p>	<p>Specialty Drug Pharmacy Program:</p> <p>Tier 4 (specialty drug): \$40 copayment for each purchase of up to a 34-day supply (\$120 copayment for 90-day supply)</p> <p>Note: You must fill your prescriptions at our specialty drug pharmacy or a Preferred retail pharmacy in order to receive benefits. Specialty drugs filled at our specialty drug pharmacy will be reimbursed at the higher level of benefits.</p>
<p>Smoking and Tobacco Cessation Medications</p> <p>If you are age 18 or over, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred Retail Pharmacy.</p> <p>To qualify, complete the Blue Health Assessment questionnaire and/or answer the initial consultation questions in the Breathe Module for smoking cessation on Blue Health Connection (BHC). For more information about the Blue Health Assessment questionnaire and the Breathe Module, see pages 113-114.</p> <p>The following medications are covered through this program:</p> <ul style="list-style-type: none"> Generic medications available by prescription: <ul style="list-style-type: none"> Bupropion ER 150 mg tablet 	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> - Bupropion SR 150 mg tablet • Brand-name medications available by prescription: <ul style="list-style-type: none"> - Chantix 0.5 mg tablet - Chantix 1 mg cont monthly pack - Chantix 1 mg tablet - Chantix starting monthly pack - Nicotrol cartridge inhaler - Nicotrol NS Spray 10 mg/ml • Over-the-counter (OTC) medications <p>Note: To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred Retail pharmacy.</p> <p>Note: These benefits apply only when all of the criteria listed above are met. Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above.</p> <p>Note: See page 57 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>
<p>Drugs from other sources</p> <ul style="list-style-type: none"> • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program <p>Note: Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription.</p> <p>Note: For covered prescription drugs and supplies purchased outside of the United States, Puerto Rico, and the U.S. Virgin Islands, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services.</p> <ul style="list-style-type: none"> • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: <ul style="list-style-type: none"> - Physician's office – Section 5(a) - Hospital (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) 	<p>Preferred: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Participating/Member: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating/Non-member: 35% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Member or Non-participating/Non-member: You pay all charges</p>

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> Please refer to page 100 for prescription drugs obtained from a Preferred retail or internet pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility 	<p>Preferred: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Participating/Member: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating/Non-member: 35% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Member or Non-participating/Non-member: You pay all charges</p>
<p>Patient Safety and Quality Monitoring (PSQM)</p> <p>We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:</p> <ul style="list-style-type: none"> Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them. Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. <p>For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).</p> <p>Prior Approval</p>		

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<p>As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage. In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval.</p> <p>Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs and supplies for weight loss</i> • <i>Drugs for orthodontic care, dental implants, and periodontal disease</i> • <i>Drugs used in conjunction with assisted reproductive technology (ART) and assisted insemination procedures</i> • <i>Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law</i> <p>Note: See page 99 for our coverage of medicines recommended under the Affordable Care Act and page 103 for smoking and tobacco cessation medications.</p> <p>Note: See Section 5(a), page 54, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.</p> <ul style="list-style-type: none"> • <i>Drugs for which prior approval has been denied or not obtained</i> • <i>Infant formula other than described on page 54</i> • <i>Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy</i> 	All charges	All charges

Covered medications and supplies - continued on next page

Standard and Basic Option

Benefit Description	You Pay	
Covered medications and supplies (cont.)	Standard Option	Basic Option
<ul style="list-style-type: none"> • <i>Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United State</i> • <i>Over-the-counter (OTC) contraceptive drugs and devices, except as described on page 98</i> • <i>Drugs used to terminate pregnancy</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*, for additional information.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **Note:** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.
- **Under Standard Option,**
 - The calendar year deductible applies only to the accidental injury benefit below. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**

Accidental injury benefit		You Pay	
Accidental injury benefit		Standard Option	Basic Option
<p>We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.</p> <p>Note: An accidental injury is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries.</p>		<p>Preferred: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Participating: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.</p>	<p>\$25 copayment per visit</p> <p>Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers. See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>

Accidental injury benefit - continued on next page

Accidental injury benefit	You Pay	
Accidental injury benefit (cont.)	Standard Option	Basic Option
<p>Note: A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.</p>	<p>Preferred: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Participating: 35% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.</p>	<p>\$25 copayment per visit</p> <p>Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers. See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 112.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	We pay	We pay	You pay
Clinical oral evaluations	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluation*	\$12	\$8	
Limited oral evaluation	\$14	\$9	
Comprehensive oral evaluation	\$14	\$9	
Detailed and extensive oral evaluation	\$14	\$9	
<i>*Limited to two per person per calendar year</i>			
Radiographs	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral complete series	\$36	\$22	
Intraoral periapical first film	\$7	\$5	
Intraoral periapical each additional film	\$4	\$3	
Intraoral occlusal film	\$12	\$7	
Extraoral first film	\$16	\$10	
Extraoral each additional film	\$6	\$4	
Bitewing – single film	\$9	\$6	
Bitewings – two films	\$14	\$9	
Bitewings – four films	\$19	\$12	
Bitewings – vertical	\$12	\$7	
Posterior-anterior or lateral skull and facial bone survey film	\$45	\$28	
	\$36	\$23	
Panoramic film			
Tests and laboratory exams	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left
Pulp vitality tests	\$11	\$7	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	We pay	We pay	You pay
			Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Palliative treatment	<u>To age 13</u>	<u>Age 13 and over</u>	
Palliative (emergency) treatment of dental pain – minor procedure	\$24	\$15	All charges in excess of the scheduled amounts listed to the left
Sedative filling	\$24	\$15	Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Preventive	<u>To age 13</u>	<u>Age 13 and over</u>	
Prophylaxis – adult*	---	\$16	All charges in excess of the scheduled amounts listed to the left
Prophylaxis – child*	\$22	\$14	Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Topical application of fluoride (prophylaxis not included) – child	\$13	\$8	
Topical application of fluoride (prophylaxis not included) – adult	---	\$8	
*Limited to two per person per calendar year			
Space maintenance (passive appliances)	<u>To age 13</u>	<u>Age 13 and over</u>	
Space maintainer – fixed – unilateral	\$94	\$59	All charges in excess of the scheduled amounts listed to the left
Space maintainer – fixed – bilateral	\$139	\$87	Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Space maintainer – removable – unilateral	\$94	\$59	
Space maintainer – removable – bilateral	\$139	\$87	
Recementation of space maintainer	\$22	\$14	
Amalgam restorations (including polishing)	<u>To age 13</u>	<u>Age 13 and over</u>	
Amalgam – one surface, primary or permanent	\$25	\$16	All charges in excess of the scheduled amounts listed to the left
Amalgam – two surfaces, primary or permanent	\$37	\$23	
Amalgam – three surfaces, primary or permanent	\$50	\$31	

Covered service - continued on next page

Standard Option dental benefits		Standard Option Only	
Covered service (cont.)	We pay	We pay	You pay
Amalgam – four or more surfaces, primary or permanent	<u>To age 13</u> \$25 \$37 \$50 \$56	<u>Age 13 and over</u> \$16 \$23 \$31 \$35	All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Filled or unfilled resin restorations	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left
Resin – one surface, anterior	\$25	\$16	Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Resin – two surfaces, anterior	\$37	\$23	
Resin – three surfaces, anterior	\$50	\$31	
Resin – four or more surfaces or involving incisal angle (anterior)	\$56	\$35	
Resin-based composite – one surface, posterior	\$25	\$16	
Resin-based composite – two surfaces, posterior	\$37	\$23	
Resin-based composite – three surfaces, posterior	\$50	\$31	
Resin-based composite – four or more surfaces, posterior	\$50	\$31	
Inlay restorations	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left
Inlay – metallic – one surface	\$25	\$16	Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Inlay – metallic – two surfaces	\$37	\$23	
Inlay – metallic – three or more surfaces	\$50	\$31	
Inlay – porcelain/ceramic – one surface	\$25	\$16	
Inlay – porcelain/ceramic – two surfaces	\$37	\$23	
Inlay – porcelain/ceramic – three or more surfaces	\$50	\$31	
Inlay – composite/resin – one surface	\$25	\$16	
Inlay – composite/resin – two surfaces	\$37	\$23	
Inlay – composite/resin – three or more surfaces	\$50	\$31	
Other restorative services	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left
Pin retention – per tooth, in addition to restoration	\$13	\$8	

Covered service - continued on next page

Basic Option dental benefits

Standard and Basic Option Section 5(g)

Basic Option dental benefits		Basic Option Only	
Covered service	We pay	You pay	
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your \$25 copayment Participating/Non-participating: Nothing	Preferred: \$25 copayment per evaluation Participating/Non-participating: You pay all charges	
Radiographs Intraoral – complete series including bitewings (<i>limited to 1 complete series every 3 years</i>) Bitewing – single film* Bitewings – two films* Bitewings – four films* *Benefits are limited to a combined total of 4 films per person per calendar year	Preferred: All charges in excess of your \$25 copayment Participating/Non-participating: Nothing	Preferred: \$25 copayment per evaluation Participating/Non-participating: You pay all charges	
Preventive Prophylaxis – adult (<i>up to 2 per calendar year</i>) Prophylaxis – child (<i>up to 2 per calendar year</i>)* Topical application of fluoride (prophylaxis not included) – child (<i>up to 2 per calendar year</i>) Sealant – per tooth, first and second molars only (<i>once per tooth for children up to age 16 only</i>)	Preferred: All charges in excess of your \$25 copayment Participating/Non-participating: Nothing	Preferred: \$25 copayment per evaluation Participating/Non-participating: You pay all charges	
<i>Not covered: Any service not specifically listed above</i>	<i>Nothing</i>	<i>All charges</i>	

Section 5(h). Special features

Special features	Description
Flexible benefits option	<p>Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a flexible benefits option. This option allows professional case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an alternative benefits agreement that includes the terms listed below, in addition to any other terms specified in the agreement.</p> <ul style="list-style-type: none"> • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the alternative benefits agreement, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. <p>If you sign the alternative benefits agreement, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us or circumstances change. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written alternative benefits agreement must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.</p> <p>Note: If we deny a request for precertification or prior approval of regular contract benefits, or if we deny regular contract benefits for services you have already received, you may dispute our denial of regular contract benefits under the OPM disputed claims process (see Section 8).</p>
Blue Health Connection	<p>Stay connected to your health and get the answers you need when you need them by using Blue Health Connection 24 hours a day, 365 days a year. Go to www.fepblue.org or call 1-888-258-3432 toll-free to check out these valuable easy-to-use services:</p> <ul style="list-style-type: none"> • Talk directly with a Registered Nurse any time of the day or night via telephone, secure email, or live chat. Ask questions, get medical advice, or get help determining when to go to see a doctor. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan. • MyBlue® Personal Health Record – Access your secure online personal health record for information such as the medications you're taking, recent test results, and medical appointments. Update, store, and track health-related information at any time. • Blue Health Assessment – Complete this online health and lifestyle questionnaire and receive additional assistance with your health care expenses. See page 114 for complete information.

	<ul style="list-style-type: none"> • Breathe™ for Smoking Cessation – Participate in this online smoking cessation program and receive your personalized action plan to quit smoking. Start by completing the Blue Health Assessment questionnaire and the initial consultation portion of the Breathe program. The program will then provide you with an individualized action plan that fits your life, your needs, and your goals. Once you complete the consultation portion of the Breathe program, you will qualify to receive certain smoking and tobacco cessation medications at no charge. See page 103 for more information. • My Multimedia Health Library offers an extensive variety of educational tools using videos, recorded messages, and colorful online material that provide up-to-date information about a wide range of health-related topics. • MyBlue® Benefit Statements – Access quarterly and annual statements of recent medical and pharmacy claims and out-of-pocket costs for each family member.
Blue Health Assessment	<p>The Blue Health Assessment questionnaire is a quick and easy online health evaluation program. Your Blue Health Assessment answers are evaluated to create a unique health action plan. You can also participate in online health programs that can help you reach your health goals in areas such as physical activity, overcoming insomnia, nutrition, weight management, overcoming back pain, stress management, help with depression, and smoking cessation (see Breathe™ for Smoking Cessation on page 113).</p> <p>When you complete your Blue Health Assessment questionnaire, you are entitled to receive a \$35 health account to be used for most qualified medical expenses. For those with Self and Family coverage, up to two (2) adult members, age 18 or over, will be eligible for the \$35 health account. We will send each eligible member a debit card to access his or her health account. Please retain your card for future use even if you have used your health account dollars as you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited.</p> <p>In addition to the \$35 health account, you are entitled to receive up to an additional \$15 for completing up to three (3) online coaching modules through Blue Health Connection. For each module completed, you will receive an additional \$5 credit to your health account. This means that you are eligible to receive up to a maximum of \$50 in your health account for the calendar year. (Please note that the \$5 credit does not apply to completion of the Breathe™ for Smoking Cessation module.)</p> <p>Visit our Web site, www.fepblue.org, for more information and to complete the questionnaire and modules, and receive your individualized results. You may also request a printed Blue Health Assessment questionnaire by calling 1-888-258-3432 toll-free.</p>
Diabetes Management Incentive Program	<p>The Diabetes Management Incentive Program is designed to provide critical health education to people with diabetes, to help assist people with diabetes in improving their blood sugar control, and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of \$75 toward a health account to be used for most qualified medical expenses. To qualify for the Diabetes Management Incentive Program, you must be age 18 or over and complete either the Blue Health Assessment (BHA) questionnaire indicating you have diabetes or the initial questionnaire of the Care™ for Diabetes coaching module available online via the Blue Health Connection Web site. For those with Self and Family coverage, this incentive program is limited to two (2) adult members.</p> <p>The following activities are rewarded through this program:</p> <ul style="list-style-type: none"> • \$10 for having your A1c test performed by a covered provider (maximum of 2 per year)

	<ul style="list-style-type: none"> • \$5 for reporting A1c levels to the Diabetes Management Incentive Program via our Web site, www.fepblue.org (maximum of 2 per year) • \$10 for receiving diabetic glucose test strips through our pharmacy program (maximum of 4 per year) • \$10 for receiving a diabetic foot exam from a covered provider (maximum of 1 per year) <p>You can also receive a maximum of 1 of the following 3 rewards:</p> <ul style="list-style-type: none"> • \$20 for enrolling in a diabetes disease management program (maximum of 1 per year) • \$20 for receiving a diabetic education visit from a covered provider (maximum of 1 per year) • \$5 for completing a web-based diabetes education quiz on our Web site, www.fepblue.org (maximum of 4 per year) <p>Note: Once you earn the maximum of \$75 through this program for the calendar year, additional eligible activities are encouraged but will not be rewarded.</p> <p>Note: For more information about this program, including eligibility and enrollment information, please visit www.fepblue.org or call the number on the back of your Service Benefit Plan ID card.</p>
MyBlue® Customer eService	<p>Visit MyBlue® Customer eService at www.fepblue.org to check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and track how you use your benefits. Additional features include:</p> <ul style="list-style-type: none"> • Online EOBs – You can view, download, and print your explanation of benefits (EOB) forms. Simply log onto MyBlue® Customer eService via www.fepblue.org and click on the “Medical & Pharmacy Claims” link. From there you can enter the desired date range and select the “EOB” link next to each claim to access your EOB. • Opt Out of Paper EOBs – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs. You can opt out of receiving paper EOBs and access your EOBs exclusively online. From the main menu, select the “EOB Mailing Preference” link and follow the on-screen instructions. • Personalized Messages – Our EOBs provide a wide range of messages just for you and your family, ranging from preventive care opportunities to enhancements to our online services!
National Doctor & Hospital FinderSM	<p>To find nationwide listings of Preferred providers, go to www.fepblue.org and select “Provider Directory” to use our National Doctor & Hospital Finder.</p>
Care Management Programs	<p>If you have a chronic disease or complex health care needs, the Service Benefit Plan offers members two types of Care Management Programs that provide patient education and clinical support.</p> <ul style="list-style-type: none"> • Case Management: We provide members with complex health care needs with the services of a professional case manager to assess the needs of the member and when appropriate, coordinate, evaluate, and monitor the member's care. • Disease Management: We provide programs to help members adopt effective self-care habits to improve their self-management of diabetes; asthma; chronic obstructive pulmonary disease (COPD); coronary artery disease; congestive heart failure; and certain rare conditions. You may receive information from us regarding the programs available to you in your area. <p>If you have any questions regarding these programs, please contact us at the customer service number on the back of your ID card.</p>

Special features	Description
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org , adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Adjust the text size by clicking on the plus ("+") or minus ("-") boxes that appear at the top right of every page.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands.
Healthy Families Programs	Our Healthy Families suite of programs is for families with children and teens, ages 2-18. The Healthy Kids Program (also called <i>Jump 4 Health</i>) provides printable games, activities, and tools to help parents teach their children about weight management, nutrition, physical activity, and personal wellbeing. The Healthy Teens Program contains a Body Mass Index (BMI) calculator and provides guidance to help parents respond to teen behavior challenges. For more information, go to www.fepblue.org .
<i>WalkingWorks®</i> Wellness Program	<i>WalkingWorks®</i> can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online <i>WalkingWorks</i> tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. <i>WalkingWorks</i> was developed in cooperation with the President's Council on Physical Fitness and Sports.

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States, Puerto Rico, and the U.S. Virgin Islands, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 117 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either a customary percentage of the billed charge or a provider-negotiated discount as our Plan allowance. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States, Puerto Rico, and the U.S. Virgin Islands.**

Under both Standard and Basic Options, when the Plan allowance is a customary percentage of the billed charge, you pay any difference between our payment and the amount billed, in addition to any applicable coinsurance and/or copayment amounts. You must also pay any charges for noncovered services (and, under Standard Option only, any applicable deductible amount). **Under both Standard and Basic Options**, when the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts and, under Standard Option only, any applicable deductible amount. You must also pay any charges for noncovered services.

For **facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 77-79.

For **dental care** you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option**, you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option**, you must pay the \$25 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. We also have a network of professional providers who have agreed to accept a negotiated amount as payment in full for their services. The Worldwide Assistance Center can help you locate a hospital or physician in our network near where you are staying. You may also view a list of our network providers on our Web site, www.fepblue.org. You will have to file a claim to us for reimbursement for professional services unless you or your provider contacts the Worldwide Assistance Center in advance to arrange direct billing and payment to the provider.

If you are overseas and need assistance locating providers (whether in or out of our network), contact the Worldwide Assistance Center (provided by AXA Assistance – formerly Mondial Assistance), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 1-800-699-4337 or email the Worldwide Assistance Center at fepoverseas@axa-assistance.us. AXA Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States, Puerto Rico, and the U.S. Virgin Islands, send a completed Overseas Claim Form and itemized bills to: Federal Employee Program, Overseas Claims, P.O. Box 261570, Miami, FL 33126. You may also fax your claims to us at 001-410-781-7637 (or 1-888-650-6525 toll-free). We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to: Mailroom Administrator, FEP® Overseas Claims, P.O. Box 14112, Lexington, KY 40512-4112. You may also email inquiries to us through our Web site (www.fepblue.org) via MyBlue® Customer eService, or call us at 1-888-999-9862, using the appropriate AT&T country codes available at www.fepblue.org under Contact Us. You may obtain Overseas Claim Forms from our Web site, or request them through fepoverseas@axa-assistance.us or your Local Plan.

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States, Puerto Rico, and the U.S. Virgin Islands, send a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057, or fax your claim to: 001-480-614-7674. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States, Puerto Rico, or the U.S. Virgin Islands.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories), and
- The prescribing physician is licensed in the United States, Puerto Rico, or the U.S. Virgin Islands.

Please see page 101 for more information about using this program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Under Standard and Basic Options, you may order specialty drugs from the Specialty Drug Pharmacy Program only if your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories), and the prescribing physician is licensed in the United States, Puerto Rico, or the U.S. Virgin Islands. See page 102 for more information about using this program.

Non-FEHB benefits available to Plan members

The benefits on these pages are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Blue365®

Blue365® is a discount program available to all Service Benefit Plan members that provides valuable resources for healthier living such as:

- Discounted health club memberships
- Discounts on laser vision correction
- Discounts on hearing aids
- Discounts on diet and weight management programs

With Blue365, there is no paperwork to fill out. All you have to do is visit the designated Web sites to save. Please visit www.fepblue.org and click on "Blue365" to learn more about the various Blue365 vendors and discounts.

The Blue Cross and Blue Shield Service Benefit Plan may receive payments from Blue365 vendors. The Plan does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Health Club Memberships

You have access to a network of over 8,000 fitness facilities nationwide. You pay a \$25 initiation fee and a \$25 monthly fee per person, by credit card, directly to Healthways. As a member, you're entitled to unlimited visits to network facilities and all amenities included in a general membership.* You are not limited to a specific facility; you can choose to use any facility that participates in the network. There is a three-month commitment. If you stop participating for three months or more, you will need to pay an additional \$25 initiation fee. You also have access to online tools, trackers, and the Daily Challenge. For more information or to enroll, go to www.fepblue.org.

*Taxes may apply. You must be 18 or older to purchase a membership.

Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual/erectile dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, Staxyn tablet, Viagra tablet, and Yohimbine;

For weight loss: Meridia capsule and Xenical capsule;

For hair removal: Vaniqa cream; *For hair growth:* Propecia;

For skin pigmenting/depigmenting/re-pigmenting: Retinoids [Renova 0.02% (tretinoin) and Avage 0.1% (tazarotene)], Hydroquinone-containing products (Aclaro, Eldoquin Forte, Epiquin Micro, Lustra, Melanex, Melpaque, Nuquin, Obagi Products, Remergent, Solaquin Forte, and Tri-Luma), Monobenzone products (Benoquin), and Tretinoin 0.02%; and

For Miscellaneous: Peridex and Latisse.

Drugs may be added to this list as they are approved by the U.S. Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Vision Care Affinity Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 35,000 providers including optometrists, ophthalmologists, and many retail centers. For a complete description of the program or to find a provider near you, go to www.fepblue.org and click on "Benefit Plans." You may also call us at 1-800-551-3337 between 8:00 a.m. and 11:00 p.m. eastern time, Monday to Friday; 9:00 a.m. to 4:00 p.m. on Saturday; or noon to 4:00 p.m. on Sunday. Please be sure to verify that the provider participates in our Vision Care Affinity Program and ask about the discounts available before your visit, as discounts may vary.

Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the provider's usual fee, or 5% off sales pricing, on laser vision correction procedures. Call 1-800-551-3337 for the nearest location and authorization for the discount.

QualSight® LASIK

QualSight® LASIK offers a nationwide network of credentialed ophthalmologists at over 800 locations in order to provide easy and convenient access for members. Your savings represent 40% to 50% off the overall national average price of traditional LASIK. Significant savings are also provided on newer technologies such as Custom LASIK and bladeless IntraLase. Call 1-877-358-9327 for your free consultation and to see if you are a candidate for one of these procedures.

QualSight LASIK Pricing per Procedure (per eye)*

Traditional LASIK1, 2	\$895
Traditional LASIK1,2 and Lifetime Assurance Plan	\$1,295
Traditional LASIK with IntraLase2	\$1,345
Traditional LASIK with IntraLase2 and Lifetime Assurance Plan	\$1,695
Custom Refractive LASIK1,2	\$1,320
Custom LASIK1,2 with Lifetime Assurance Plan	\$1,595
Custom LASIK with IntraLase2	\$1,770
Custom LASIK with IntraLase2 and Lifetime Assurance Plan	\$1,995
Conductive Keratoplasty (CK)2	\$ 995

1 Pricing includes all FDA-approved procedures (with no additional charges for astigmatism or higher amounts of correction) and surface ablation procedures (PRK, LASEK, Epi-LASIK) as necessary, and as offered at individual network practices. Pricing does not include any required prescription or over-the-counter drugs.

2 When offered by participating network providers. *A small percentage of providers may charge more for certain procedures, resulting in a higher fee for the procedure. You will be notified of any additional amount prior to scheduling your pre-operative examination with these providers.*

**Provider participation may vary.*

ARAG® Legal Center

Members have access to The Education Center which offers a collection of legal tools and resources that provide helpful tips and simple explanations for complex legal terms and scenarios, as well as guidance on where to turn for more information and assistance. The center includes a secure Personal Information Organizer, a law guide, videos, and an e-newsletter. To access this free service, visit www.fepblue.org, Free Services and Discounts, and select the ARAG Legal Center link.

DIY Docs™

Members also have the opportunity to purchase a **DIY Docs™** package for a low annual subscription rate of \$69.95 (30% off the \$99 retail rate). DIY Docs members receive access to more than 300 legally valid documents. These documents are authored and reviewed by attorneys for accuracy and to ensure they are legally valid in all 50 states. Available DIY Docs include a Will, Living Will, Powers of Attorney, Medical Authorization for a Minor, Bill of Sale, Contract, Residential Lease, and much more.

The DIY Docs package includes an easy-to-use document assembly tool that walks a member through an interview process, with answers resulting in the completed document. DIY Docs is available online 24 hours a day, 365 days a year, and provides secure storage to create, update, and print documents at any time. For more information or to purchase DIY Docs, visit www.fepblue.org, Free Services and Discounts, and select the ARAG Legal Center link.

Federal DentalBlue

Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. Federal DentalBlue is available to members who reside in Alabama, Illinois, New Mexico, Oklahoma, or Texas. To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your local Blue Cross and Blue Shield Plan. For more information, please contact us at:

Alabama: 1-800-492-8872 or www.bcbsal.org

Illinois: 1-866-431-1595 or www.yourfederaldental.com

New Mexico: 1-866-431-1604 or www.yourfederaldental.com

Oklahoma: 1-866-431-1602 or www.yourfederaldental.com

Texas: 1-866-431-1598 or www.yourfederaldental.com

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 (*You need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events (see definition on page 139).
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 134), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 135), or State premium taxes however applied.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 16.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures for the treatment of morbid obesity (see pages 59 and 60); and, those nutritional counseling services specifically listed on pages 34, 38, 41, and 75.
- Services you receive from a provider that are outside the scope of the provider's licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*.
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.
- Services of standby physicians.
- Self-care or self-help training.

- Custodial care.
- Personal comfort items such as beauty and barber services, radio, television, or telephone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.
- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on pages 37-41 and 79; and certain routine services associated with covered clinical trials (see page 129).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) or ABA therapy.
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for after-hours care, except when associated with services provided in a physician's office.
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring precertification or prior approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment, home nursing care, or physical, occupational, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for dental care to repair accidental injury to sound natural teeth should include documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, through the Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See pages 123-124 for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.)

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our Web site, www.fepblue.org, visit the “Pharmacy” page, and click on the “Retail Pharmacy” link for your enrollment option (Standard or Basic) to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see pages 20-21).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

- (1) Complete the initial mail order form;
- (2) Enclose your prescription and copayment;
- (3) Mail your order to CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590; and
- (4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Note: Specialty drugs will not be dispensed through the Mail Service Prescription Drug Program. See page 124 for information about the Specialty Drug Pharmacy Program.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Specialty Drug Pharmacy Program

Standard and Basic Options: If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will deliver your specialty medication directly to you or your doctor's office in about two weeks. After that, to order refills call the same number and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our Web site, www.fepblue.org.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a five-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 116 and 117 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo, and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your explanation of benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the procedure or treatment code and its corresponding meaning.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process **if you disagree with our decision on your post-service claim** (a claim where services, drugs, or supplies have already been provided). In Section 3, ***If you disagree with our pre-service claim decision***, we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may be able to appeal directly to the U.S. Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please visit www.fepblue.org.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, call us at the customer service number on the back of your Service Benefit Plan ID card, or send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.</p>
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or

- b) Write to you and maintain our denial or
- c) Ask you or your provider for more information.
 - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
 - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street, NW, Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service number on the back of your Service Benefit Plan ID card. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. eastern time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at <http://www.NAIC.org>.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor’s benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payor (see page 135). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan’s copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan’s payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced, at the Carrier's option, by the Carrier, by any of the Local Plans that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
 - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
 - Uninsured and underinsured motorist coverage
 - Workers' Compensation benefits
 - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

If you are a participant in an approved clinical trial, this health Plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition, whether the patient is in a clinical trial or is receiving standard therapy. We provide benefits for these types of costs at the benefit levels described in Section 5 (*Benefits*) when the services are covered under the Plan and we determine that they are medically necessary.
- Extra care costs – costs of covered services related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. This Plan covers extra care costs related to taking part in an approved clinical trial for a covered stem cell transplant such as additional tests that a patient may need as part of the clinical trial protocol, but not as part of the patient’s routine care. For more information about approved clinical trials for covered stem cell transplants, see pages 68-69. Extra care costs related to taking part in any other type of clinical trial are not covered. We encourage you to contact us at the customer service number on the back of your ID card to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

• What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 132.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778), to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 134 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 19 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When the Original Medicare Plan is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
 - Inpatient hospital per-admission copayments; and
 - Inpatient Member and Non-member hospital coinsurance.
- Under **Basic Option**, we will waive our:
 - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
 - Calendar year deductible;
 - Coinsurance and copayments for inpatient and outpatient services and supplies provided by physicians and other covered health care professionals; and
 - Coinsurance for outpatient facility services.
- Under **Basic Option**, we will waive our:
 - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You can find more information about how our Plan coordinates benefits with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

• **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

• **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 18 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on:

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	Then you are responsible for:	
If your physician:	Standard Option:	Basic Option:
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	your deductibles, coinsurance, and copayments.	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount.	all charges.
Does not participate with Medicare, and is in our Preferred network <i>Note:</i> In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.	your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount.
Does not participate with Medicare and is not in our Preferred network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.	all charges.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: Under Basic Option, you must see **Preferred** providers in order to receive benefits. See page 18 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of terms we use in this brochure

Accidental injury	An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. Note: Injuries to the teeth while eating are not considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.
Admission	The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.
Agents	Medicines and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medicines and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT Scans, MRIs, PET Scans, lung scans, and X-rays, as well as those injected into the joint.
Assignment	An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.
Assisted reproductive technology (ART)	Fertility treatments in which both eggs and sperm are manipulated. In general, assisted reproductive technology (ART) procedures involve retrieval of eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Carrier	The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.
Case management	A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2002). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC or NCQA. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.
Clinical trials cost categories	<ul style="list-style-type: none"> • Routine care costs – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes
Coinurance	Coinurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 24.

Concurrent care claims	A claim involving care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. See pages 21 and 22 in Section 3.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 24.
Cosmetic surgery	Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:</p> <ol style="list-style-type: none"> 1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing; 2. Homemaking, such as preparing meals or special diets; 3. Moving the patient; 4. Acting as companion or sitter; 5. Supervising medication that can usually be self-administered; or 6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems. <p>Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial care.</p>
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 24.
Diagnostic service	An examination or test of an individual with signs, symptoms, or a probability of having a specific disease to determine the presence of that disease; or an examination or test to evaluate the course of treatment for a specific disease.
Durable medical equipment	<p>Equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury.
Experimental or investigational services	Experimental or investigational shall mean:

- a. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and approval for marketing has not been given at the time it is furnished; or
- b. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- c. Reliable evidence shows that the consensus of opinion among experts regarding the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- d. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

Reliable evidence shall mean only evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations, such as:

- a. Published reports and articles in the authoritative medical and scientific literature;
- b. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- c. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Generic alternative	A generic alternative is an FDA-approved generic drug in the same class or group of drugs as your brand-name drug. The therapeutic effect and safety profile of a generic alternative are similar to your brand-name drug, but it has a different active ingredient.
Generic equivalent	A generic equivalent is a drug whose active ingredients are identical in chemical composition to those of its brand-name counterpart. Inactive ingredients may not be the same. A generic drug is considered "equivalent," if it has been approved by the FDA as interchangeable with your brand-name drug.
Group health coverage	Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than \$200 per day for hospitalization (including extension of any of these benefits through COBRA).
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Health Risk Assessment (HRA)	A questionnaire designed to assess your overall health and identify potential health risks. Service Benefit Plan members have access to the Blue Cross and Blue Shield HRA (called the "Blue Health Assessment") which is supported by a computerized program that analyzes your health and lifestyle information and provides you with a personal and confidential health action plan that is protected by HIPAA privacy and security provisions. Results from the Blue Health Assessment include practical suggestions for making healthy changes and important health information you may want to discuss with your health care provider. For more information, visit our Web site, www.fepblue.org .

Intensive outpatient care A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Local Plan A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- a. In accordance with generally accepted standards of medical practice in the United States; and
- b. Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient’s illness, injury, disease, or its symptoms; and
- c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient’s illness, injury, or disease, or its symptoms; and
- d. Not part of or associated with scholastic education or vocational training of the patient; and
- e. In the case of inpatient care, only provided safely in the acute inpatient hospital setting.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.

The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

**Mental conditions/
substance abuse** Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Never Events	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.
Observation services	Hospital outpatient services ordered by the physician to assess whether the member needs to be admitted as an inpatient or can be discharged. If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services – including “ observation services ” – are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.
Partial hospitalization	An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.
Plan allowance	<p>Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:</p> <ul style="list-style-type: none"> • PPO providers - Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with CVS Caremark) have agreed to accept as payment in full, when we pay primary benefits. <p>Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 108 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)</p> <ul style="list-style-type: none"> • Participating providers - Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. • Non-participating providers - We have no agreements with these providers to limit what they can bill you for their services. This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive. We determine our allowance as follows:

- For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;
- For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is the average amount for all outpatient surgical claims combined that we pay nationally to contracting and non-contracting facilities. This allowance applies to all of the covered surgical services billed by the hospital and is the same regardless of the type of surgery performed. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient surgical procedure, please call us before your surgery at the customer service number on the back of your ID card to obtain the current allowed amount and assistance in estimating your total out-of-pocket expenses.

Please keep in mind that Non-member facilities may bill you for any difference between the allowance and the billed amount. You may be able to reduce your out-of-pocket expenses by using a Preferred hospital for your outpatient surgical procedure. To locate a Preferred provider, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card;

- For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the billed amount (minus any amounts for noncovered services);
- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the current year's Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greatest of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained; or 2) 100% of the current year's Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained; or 3) an allowance based on equivalent Preferred provider services that is calculated in compliance with the Affordable Care Act.
- For prescription drugs furnished by retail and internet pharmacies that do not contract with CVS Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth by Medi-Span® in its national drug data file; and
- For services you receive outside of the United States, Puerto Rico, and the U.S. Virgin Islands from providers that do not contract with us or with AXA Assistance, our allowance is a customary percentage of the billed charge.

**Important notice about
Non-participating
providers!**

Note: Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive. Non-participating and Non-member providers are under no obligation to accept our allowance as payment in full. If you use Non-participating and/or Non-member providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances involving covered Non-participating professional care – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment. You can reduce your out-of-pocket expenses by using Preferred providers whenever possible. To locate a Preferred provider, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. We encourage you to always use Preferred providers for your care.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than \$5,000 for an episode of care, your responsibility will be limited to \$5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive during an emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services), plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as aradiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or pediatric sub-specialist; and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providers in a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 86-87).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see page 28 and pages 116-117.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Pre-service claims

Those claims (1) that require precertification or prior approval, and (2) where failure to obtain precertification or prior approval results in a reduction of benefits.

Preferred provider organization (PPO) arrangement	An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail and internet pharmacies, between pharmacies and CVS Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, CVS Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.
Preventive Care, Adult	Adult preventive care includes the following services when performed as part of a routine annual physical examination: chest X-ray; EKG; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for alcohol/substance abuse; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings and screening for abdominal aortic aneurysms as specifically stated in this brochure; and routine immunizations as licensed by the U.S. Food and Drug Administration (FDA).
Prior approval	<p>Written assurance that benefits will be provided by:</p> <ol style="list-style-type: none"> 1. The Local Plan where the services will be performed; or 2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies), the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. <p>For more information, see the benefit descriptions in Section 5 and <i>Other services</i> in Section 3, under <i>You need prior Plan approval for certain services</i>, on pages 20-21.</p>
Residential treatment centers	<p>Residential treatment centers (RTCs) are live-in facilities (although not licensed as hospitals) that offer treatment for a variety of addiction, behavioral, and emotional problems. These programs may include drug and alcohol treatment, confidence building, military-style discipline, and psychological counseling. Many of the programs are intended to provide a less-restrictive alternative to incarceration or hospitalization, or to offer intervention for troubled individuals. RTC programs are often designed to treat children and adolescents and have been described in a variety of ways, including "therapeutic boarding schools," "behavioral modification facilities," "emotional growth academies," and "boot camps."</p> <p>No standardized definitions exist for RTCs or for the programs they administer. RTC programs are not regulated by the federal government. Although some RTCs may meet state licensing requirements and standards, certain types of residential facilities are exempt from licensing or monitoring by the state. Accreditation of these facilities, their clinicians, and staff members varies significantly from state to state.</p> <p>Benefits are not available for services performed or billed by RTCs. If you have questions about treatment at an RTC, please contact us at the customer service number listed on the back of your ID card.</p>
Routine services	Services that are not related to a specific illness, injury, set of symptoms, or maternity care (other than those routine costs associated with a clinical trial as defined on page 129).
Screening service	An examination or test of an individual with no signs or symptoms of the specific disease for which the examination or test is being done, to identify the potential for that disease and prevent its occurrence.

Sound natural tooth	A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.
Specialty drugs	<p>Pharmaceutical products that are included on the Service Benefit Plan Specialty Drug List that are typically high in cost and have one or more of the following characteristics:</p> <ul style="list-style-type: none"> • Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology • Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects • Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy • Unique patient compliance and safety monitoring requirements • Unique requirements for handling, shipping, and storage
Transplant period	A defined number of consecutive days associated with a covered organ/tissue transplant procedure.
Urgent care claims	<p>A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:</p> <ul style="list-style-type: none"> • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. <p>Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.</p> <p>If you believe your claim qualifies as an urgent care claim, please contact our customer service department using the number on the back of your Service Benefit Plan ID card and tell us the claim is urgent. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.</p>
Us/We/Our	"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.
You/Your	"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is \$2,500.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician-prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Note:** If you are enrolled in the HCFSA, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSA without submitting an FSAFEDS claim. When the Blue Cross and Blue Shield Service Benefit Plan receives a claim for benefits, the Plan forwards information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs – there's no need for a claim form or receipt! Reimbursement is made directly to your bank from your HCFSA account via Electronic Funds Transfer. You may need to file a paper claim to FSAFEDS in certain situations. Visit www.FSAFEDS.com for more information. FSAFEDS is not part of the Service Benefit Plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP***It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program – *PCIP*

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool, then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

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		Oral and maxillofacial,.....	63		
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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2013

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 per person (\$700 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; 15%* of our allowance; \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists Non-PPO: 35%* of our allowance	34-35, 37-40
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: \$250 per admission Non-PPO: \$350 per admission, plus 35% of our allowance	74-76
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	77-79
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	85-86, 88
<ul style="list-style-type: none"> Medical emergency 	PPO urgent care: \$40 copayment; PPO and Non-PPO emergency room care: 15%* of our allowance; Regular benefits for physician and hospital care* provided in other than the emergency room/PPO urgent care center; Ambulance transport services: \$100 per day for ground ambulance (no deductible); \$150 per day for air or sea ambulance (no deductible)	85, 87-88
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$20 office visit copay; \$250 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; \$350 per inpatient admission, plus 35% of our allowance	89-92
Prescription drugs	Retail Pharmacy Program:	93-106

	<ul style="list-style-type: none"> • PPO: 20% of our allowance generic (15% if you have Medicare)/30% of our allowance preferred brand-name/45% of our allowance non-preferred brand-name/30% of our allowance specialty; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply <p>Mail Service Prescription Drug Program:</p> <ul style="list-style-type: none"> • \$15 generic (\$10 if you have Medicare)/\$70 preferred brand-name/\$95 non-preferred brand-name per prescription; up to a 90-day supply <p>Specialty Drug Pharmacy Program:</p> <p>\$80 per prescription; up to a 90-day supply</p>	
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	63, 107-111
Special features:	Blue Health Connection; Blue Health Assessment; Diabetes Management Incentive Program; MyBlue [®] Customer eService; National Doctor & Hospital Finder SM ; care management programs; flexible benefits option; travel benefit/services overseas; Healthy Families Programs; and <i>WalkingWorks</i> [®] Wellness Program	113-115
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000 (PPO) or \$7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	28-29

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2013

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 14. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; \$25 per office visit for primary care physicians and other health care professionals; \$35 per office visit for specialists Non-PPO: You pay all charges	34-35, 37-40
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: \$150 per day up to \$750 per admission Non-PPO: You pay all charges	74-76
<ul style="list-style-type: none"> Outpatient 	PPO: \$100 per day per facility Non-PPO: You pay all charges	77-79
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	PPO: \$50 copayment for urgent care; \$125 copayment for emergency room care Non-PPO: \$125 copayment for emergency room care; you pay all charges for care in settings other than the emergency room Ambulance transport services: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	85-86, 88
<ul style="list-style-type: none"> Medical emergency 	Same as for accidental injury	85, 87-88
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$25 office visit copayment; \$150 per day up to \$750 per inpatient admission Non-PPO: You pay all charges	89-92
Prescription drugs:	Retail Pharmacy Program:	93-106

	<ul style="list-style-type: none"> • PPO: \$10 generic/\$40 preferred brand-name per prescription/50% coinsurance (\$50 minimum) for non-preferred brand-name drugs/\$50 specialty. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges <p>Specialty Drug Pharmacy Program:</p> <p>\$40 per prescription. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments</p>	
Dental care	<p>PPO: \$25 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; \$25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery</p> <p>Non-PPO: You pay all charges</p>	63, 107-108, 112
Special features:	Blue Health Connection; Blue Health Assessment; Diabetes Management Incentive Program; MyBlue [®] Customer eService; National Doctor & Hospital Finder SM ; care management programs; flexible benefits option; travel benefit/services overseas; Healthy Families Programs; and <i>Walking Works</i> [®] Wellness Program	113-115
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000 (PPO) per contract per year; some costs do not count toward this protection	28-29

2013 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC), and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN); Postal Career Executive Service (PCES) employees (see RI 70-2EX); and non-career employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Standard Option Self Only	104	\$190.84	\$85.91	\$413.49	\$186.14
Standard Option Self and Family	105	\$424.95	\$200.14	\$920.73	\$433.63
Basic Option Self Only	111	\$177.23	\$59.07	\$383.99	\$127.99
Basic Option Self and Family	112	\$414.98	\$138.32	\$899.12	\$299.70
High Option Self Only		0	0	0	0
High Option Self and Family		0	0	0	0
Standard Option Self Only		0	0	0	0
Standard Option Self and Family		0	0	0	0

Exhibit M

Blue Cross[®] and Blue Shield[®] Service Benefit Plan

<http://www.fepblue.org>



2014

**A fee-for-service plan (standard and basic option)
with a preferred provider organization**

IMPORTANT:

- Rates: Back Cover
- Changes for 2014: Page 15
- Summary of benefits: Page 153

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details.

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

- 104 Standard Option - Self Only
- 105 Standard Option - Self and Family
- 111 Basic Option - Self Only
- 112 Basic Option - Self and Family



The Case Management programs for this Plan are accredited through URAC or NCQA, or through Health Plan accreditation from NCQA.

See the 2014 FEHB Guide for more information on accreditation.



Authorized for distribution by the:



**United States
Office of Personnel Management**

Healthcare and Insurance
www.opm.gov/healthcare-insurance

RI 71-005

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. For customer service assistance, visit our Web site, www.fepblue.org, or contact your Local Plan at the telephone number appearing on the back of your ID card.

The Blue Cross and Blue Shield Association is the Carrier of the Plan. The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan

1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on pages 15-17. Rates are shown on the back cover of this brochure.

Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) Web site at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this Plan meets the minimum value standard for the benefits the Plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.
 - If we do not resolve the issue:

CALL — THE HEALTH CARE FRAUD HOTLINE

1-877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Do not assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
 - “Exactly what will you be doing?”
 - “About how long will it take?”
 - “What will happen after surgery?”
 - “How can I expect to feel during recovery?”
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct never events, if you use Service Benefit Plan Preferred or Member hospitals. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**
We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)**
Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) Web site at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard**
The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this Plan meets the minimum value standard for the benefits the Plan provides.
- **Where you can get information about enrolling in the FEHB Program**
See www.opm.gov/healthcare-insurance/healthcare-for-enrollment information as well as:
 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies who participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

 - When you may change your enrollment
 - How you can cover your family members
 - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
 - What happens when your enrollment ends
 - When the next Open Season for enrollment begins

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
- **Types of coverage available for you and your family**
Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Family member coverage**

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB Web site at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2013 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health benefits coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Health Insurance Market Place**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a Web site provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/healthcare-insurance/healthcare and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 1. How this Plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are “Preferred providers.” When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, and select “Provider Directory” to use our National Doctor & Hospital FinderSM. You can reach our Web page through the FEHB Web site, www.opm.gov/healthcare-insurance.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as “Preferred.”** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as “Participating” providers. If they are facilities, we refer to them as “Member” facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as “Non-participating providers” generally, although if they are facilities we refer to them as “Non-member facilities.”** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see pages 145-147). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 21 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM’s FEHB Web site (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. **Note:** As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our Web site at www.fepblue.org.

Section 2. Changes for 2014

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (*Benefits*). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 156.)
- For Self and Family contracts, your catastrophic out-of-pocket maximum is now \$6,000 per year when you use Preferred providers and \$8,000 per year when you use a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum was \$5,000 for Preferred provider services and \$7,000 for both Preferred and Non-preferred providers. (See page 31.)
- Your calendar year deductible is now included in the out-of-pocket catastrophic protection maximum, in addition to coinsurance and copayments. Previously, the out-of-pocket maximum did not include your calendar year deductible. (See page 31.)
- We now provide benefits for two hours of home nursing care per day, up to a maximum of 50 visits per calendar year. Previously, benefits were only available for up to 25 visits per calendar year. (See page 59.)
- We modified the list of generic drug replacements included in our Standard Option Generic Incentive Program. (See page 101.)
- Your copayment for Tier 2 preferred brand-name drugs purchased through the Mail Service Prescription Drug Program is now \$80 per prescription for up to a 90-day supply. Previously, you paid \$70 for Tier 2 preferred brand-name drugs. (See page 107.)
- Your copayment for Tier 3 non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program is now \$105 per prescription for up to a 90-day supply. Previously, you paid \$95 for Tier 3 non-preferred brand-name drugs. (See page 107.)
- We now have two Tiers of specialty drugs: Tier 4 includes preferred specialty drugs and Tier 5 includes non-preferred specialty drugs. Previously, all specialty drugs were included in Tier 4. (See page 99.)
- You may fill new prescriptions of Tier 4 or Tier 5 specialty drugs at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program. You must use the Specialty Drug Pharmacy Program for any refills of the same specialty drug. We will cover supplies of up to 30 days for your first three fills of the same Tier 4 or Tier 5 prescription. You may receive supplies of up to 90 days beginning with your fourth fill. Previously, you could use a retail pharmacy or our specialty pharmacy to purchase 90-day supplies of new or continuing specialty drugs. (See pages 105 and 108.)
- Your copayment for Tier 4 preferred specialty drugs dispensed by the Specialty Drug Pharmacy Program is now \$35 for up to a 30-day supply, and \$95 for up to a 90-day supply. Previously, your copayment for Tier 4 specialty drugs obtained through the Specialty Drug Pharmacy Program was \$80 for each 90-day supply. (See page 108.)
- You pay 30% of the Plan allowance for Tier 5 non-preferred specialty drugs dispensed by a Preferred retail pharmacy. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 105.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed by the Specialty Drug Pharmacy Program is \$55 for up to a 30-day supply, and \$155 for up to a 90-day supply. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 108.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 156.)
- For Self Only contracts, the catastrophic out-of-pocket maximum for coinsurance and copayments is now \$5,500 per year when you use Preferred providers. For Self and Family contracts, the maximum is now \$7,000 per year when you use Preferred providers. Previously, the catastrophic out-of-pocket maximum was \$5,000 for Preferred provider services for both Self Only and Self and Family contracts. (See page 31.)
- The coinsurance amount you pay for non-preferred brand-name drugs purchased at Preferred retail pharmacies now counts toward your annual catastrophic protection out-of-pocket maximum. Previously, this amount was not included in your out-of-pocket maximum. (See page 31.)
- Your copayment for neurological testing performed by a Preferred professional provider is now \$40. Previously, you had no copayment for these services. (See page 39.)
- Your copayment for diagnostic tests such as EEGs, ultrasounds, and X-rays performed by a Preferred professional provider is now \$40. Previously, your copayment for EEGs, ultrasounds, and X-rays was \$25. (See page 39.)

- Your copayment for the diagnostic studies and radiological services listed on page 40 in Section 5(a) is now \$100 when performed by a Preferred professional provider. Previously, your copayment for these services was \$75. (See page 40.)
- Your copayment for the outpatient **diagnostic testing and treatment services** listed on page 82 in Section 5(c) is now \$150 per day per facility, when you receive those services at a Preferred, Member, or Non-member facility. Previously, your copayment for these services was \$100 per day per facility. (See page 82.)
- Your copayment for outpatient **diagnostic testing services** such as EEGs, ultrasounds, and X-rays is now \$40 per day per facility, when you receive those services at a Preferred, Member, or Non-member facility. Previously, your copayment for these services was \$25 per day per facility. (See page 82.)
- We now provide benefits for up to 10 visits per year for acupuncture performed by Preferred providers acting within the scope of their license or certification in the state where the services are provided. Previously, Basic Option benefits were available for acupuncture only when provided by a physician. (See page 60.)
- Your copayment for surgical procedures performed outside of the office setting is now \$200 per performing surgeon. Previously, your copayment for surgical procedures performed in any setting was \$150 per performing surgeon. (See pages 63-73.)
- Your copayment for an inpatient admission to a Preferred facility is \$175 per day up to a maximum of \$875 for unlimited days. Previously, your copayment for an inpatient admission was \$150 per day up to a maximum of \$750 for unlimited days. (See pages 78-79, and 96.)
- Your copayment for a maternity inpatient admission to a Preferred facility is \$175. Previously, your copayment for a maternity inpatient admission was \$150. (See pages 46 and 79.)
- For Tier 1 (generic), Tier 2 (preferred brand-name), and Tier 3 (non-preferred brand-name) prescriptions obtained from a Preferred retail pharmacy, you may purchase up to a 30-day supply per copayment. Previously, you were limited to a 34-day supply per copayment. (See pages 100 and 105.)
- Your copayment for Tier 2 preferred brand-name drugs purchased at a Preferred retail pharmacy is now \$45 per prescription for up to a 30-day supply. Previously, you paid \$40 for Tier 2 preferred brand-name drugs. (See page 105.)
- Your minimum copayment for Tier 3 non-preferred brand-name drugs purchased at a Preferred retail pharmacy is now \$55 for each purchase of up to a 30-day supply. Previously, you paid a minimum of \$50 for Tier 3 non-preferred brand-name drugs. (See page 105.)
- We now have two Tiers of specialty drugs: Tier 4 includes preferred specialty drugs and Tier 5 includes non-preferred specialty drugs. Previously, all specialty drugs were included in Tier 4. (See page 99.)
- You may fill new prescriptions of Tier 4 or Tier 5 specialty drugs at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program. You must use the Specialty Drug Pharmacy Program for any refills of the same specialty drug. We will cover supplies of up to 30 days for your first three fills of the same Tier 4 or Tier 5 prescription. You may receive supplies of up to 90 days beginning with your fourth fill. Previously, you could use a retail pharmacy or our specialty pharmacy to purchase 90-day supplies of new or continuing specialty drugs. (See pages 105 and 108.)
- Your copayment for Tier 4 preferred specialty drugs dispensed by a Preferred retail pharmacy is now \$60, and benefits are limited to one purchase of up to a 30-day supply for each prescription filled. Previously, your copayment for Tier 4 specialty drugs purchased at a Preferred retail pharmacy was \$50 for up to a 34-day supply or \$150 for up to a 90-day supply; you could also receive refills from a Preferred retail pharmacy. (See page 105.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed by a Preferred retail pharmacy is \$80, and benefits are limited to one purchase of up to a 30-day supply for each prescription filled. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 105.)
- Your copayment for Tier 4 preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is now \$50 for up to a 30-day supply, and \$140 for up to a 90-day supply. Previously, your copayment for Tier 4 specialty drugs obtained through the Specialty Drug Pharmacy Program was \$40 for up to a 34-day supply or \$120 for a 90-day supply. (See page 108.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is \$70 for up to a 30-day supply, and \$195 for up to a 90-day supply. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 108.)

Changes to both our Standard and Basic Options

- Subject to the criteria appearing on page 18, we now cover any licensed medical practitioner for covered services performed within the scope of that license, as required by Section 2706(a) of the Public Health Service Act (PHSA). Previously, benefits for certain medical practitioners were limited to services performed in Medically Underserved Areas (MUAs).
- You are entitled to receive a \$40 health account to be used for qualified medical expenses when you complete a Blue Health Assessment (BHA) questionnaire. You are also entitled to receive up to an additional \$35 for achieving goals related to improving exercise and nutrition, reducing stress levels, managing your weight, and improving emotional health. Previously, you were entitled to receive a \$35 health account when you completed a BHA and up to an additional \$15 for completing up to three (3) online coaching sessions. [See Section 5(h).]
- We now provide preventive care benefits for testing for deleterious mutations in BRCA1 and BRCA2 genes in females, age 18 and over, who have not personally been diagnosed with breast or ovarian cancer. Benefits are limited to one BRCA test per lifetime whether the test is covered under Preventive Care benefits (see page 43) or is covered under Diagnostic testing benefits (see page 40). Previously, Preventive Care benefits were not available for this service. (See page 43.)
- We now limit benefits for diagnostic BRCA testing for members with a personal history of cancer to one test per lifetime whether the test is covered under Preventive Care benefits (see page 43) or is covered under Diagnostic testing benefits (see page 40). Previously, benefits for diagnostic BRCA testing were not subject to a limit.
- We now provide benefits for wigs for hair loss due to cancer treatment, limited to a maximum of \$350 for one wig per lifetime. Previously, benefits were only available for wigs for hair loss due to chemotherapy for the treatment of cancer. (See page 56.)
- Benefits for chiropractic care are no longer limited to one office visit and one set of X-rays per year. See page 37 for the benefits we provide for office visits and pages 39 and 40 for our coverage of radiological services performed by covered professional providers.
- We now provide benefits for insulin and diabetic supplies only when obtained from a retail pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. This requirement does not apply if you have Medicare Part B as primary. Previously, insulin and diabetic supplies were also covered when obtained from physicians and other health care professionals, including medical supply companies and durable medical equipment providers. (See pages 58, 102, and 111.)
- We now provide benefits in full for Vitamin D supplements for adults, age 65 and over, as recommended under the Affordable Care Act. Previously, benefits were not available for Vitamin D supplements. (See page 104.)
- We now use an Overseas Fee Schedule as our Plan allowance for services performed overseas by professional providers that do not contract with us or with AXA Assistance. Previously, we used a customary percentage of the billed charge as our Plan allowance. (See pages 121 and 146.)
- We now consider the Medicare Part B Drug Average Sale Price (ASP) for drugs dispensed or administered by Non-participating physicians and other covered health care professionals when we determine our Plan allowance. Previously, we did not consider the Average Sale Price when determining our Plan allowance for drugs. (See page 146.)
- We no longer provide benefits for heart-lung transplants performed at Blue Distinction Centers for Transplants. Previously, benefits were available for heart-lung transplants performed at these types of facilities.

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP[®] Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any “covered professional provider” or “covered facility provider.” How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those “covered professional providers” or “covered facility providers” that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 21 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

The term “primary care provider” includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

We provide benefits for the services of covered professional providers (see below for definition), as required by Section 2706(a) of the Public Health Service Act (PHSA). Benefits are available for covered services provided anywhere in the United States, Puerto Rico, and the U.S. Virgin Islands. Coverage of practitioners is not determined by your state’s designation as a Medically Underserved Area (MUA). As reflected in Section 5, the Plan does limit coverage for some services, in accordance with accepted standards of clinical practice regardless of the geographic area.

- **Under Standard Option**, we cover any licensed professional provider for covered services performed within the scope of that license.
- **Under Basic Option**, we cover any licensed professional provider who is **Preferred** for covered services performed within the scope of that license.

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified. Your Local Plan is responsible for determining the provider’s licensing status and scope of practice.

If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan. See below for additional requirements that apply to the practitioners listed.

Physicians – Doctors of medicine (M.D.); Doctors of osteopathy (D.O.); Doctors of dental surgery (D.D.S.); Doctors of medical dentistry (D.M.D.); Doctors of podiatric medicine (D.P.M.); Doctors of optometry (O.D.); and Doctors of Chiropractic/chiropractors (D.C.).

Other Covered Health Care Professionals – Professionals such as the medical practitioners listed below, when they provide covered services *and* meet the state’s applicable licensing or certification requirements; the requirements of the Local Plan; and any other requirements as specifically listed below:

- **Audiologist** – A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Clinical Psychologist** – A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker** – A social worker who (1) has a master’s or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator** – A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Dietician** – A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory** – A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Lactation Consultant** – A person who is licensed as a Registered Nurse in the United States (or appropriate equivalent if providing services overseas) and is licensed or certified as a lactation consultant by a nationally recognized organization.
- **Mental Health or Substance Abuse professional** – A professional who is licensed by the state where the care is provided to provide mental health and/or substance abuse services within the scope of that license.
- **Certified Midwife** – A person who is certified by the American College of Nurse Midwives or the American Midwifery Certification Board, *and* is licensed, certified, or authorized to practice as a Certified Nurse Midwife (CNM) or Certified Midwife (CM) in the state or jurisdiction in which the services are provided.
- **Nurse Practitioner/Clinical Specialist** – A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic** – A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient “office” services rather than facility charges.
- **Nutritionist** – A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist** – A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant** – A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.

• Covered facility providers

Covered facilities include those listed below, when they meet the state’s applicable licensing or certification requirements.

Hospital – An institution, or a distinct portion of an institution, that:

- (1) Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
- (2) Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and

- (3) Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

Freestanding Ambulatory Facility – A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

- (1) Provides services in an outpatient setting;
- (2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
- (3) Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
- (4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

Blue Distinction Centers[®]

Certain facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, and Complex and Rare Cancers. These facilities meet objective quality criteria established with input from expert physician panels, surgeons, and other medical professionals. Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise.

We cover facility costs for specialty care at designated Blue Distinction Centers at Preferred benefit levels, which means that your out-of-pocket expenses for specialty facility services are limited.

Facility care that is not part of the Blue Distinction Program is reimbursed according to the network status of the facility. In addition, some Blue Distinction Centers may use professional providers who do not participate in our provider network. Non-participating providers have no agreements with us to limit what they can bill you. This is why it's important to always request Preferred providers for your care. For more information, see pages 27-32 in Section 4, *Your costs for covered services*, or call your Local Plan at the number listed on the back of your ID card. For listings of Preferred providers in your area, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder.

If you are considering covered bariatric surgery, cardiac procedures, knee or hip replacement, spine surgery, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. To locate a Blue Distinction Center, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number listed on the back of your ID card.

Blue Distinction Centers for Transplants[®]

In addition to Preferred transplant facilities, you have access to Blue Distinction Centers for Transplants. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. We provide enhanced benefits for covered transplant services performed at these designated centers during the transplant period (see page 148 for the definition of "transplant period").

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the \$250 per admission copayment under Standard Option, or the \$175 per day copayment (\$875 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services.

Regular benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period. (Regular benefit levels and cost-sharing amounts also apply to services unrelated to a covered transplant.)

Blue Distinction Centers for Transplants are available for the following types of transplants: heart; single or double lung; liver; pancreas (pancreas transplant alone, pancreas after kidney, simultaneous pancreas-kidney); and autologous or allogeneic blood or marrow stem cell (see page 75 for limitations).

Note: Certain stem cell transplants **must** be performed at a Blue Distinction Centers for Transplants facility (see pages 70-71).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

Cancer Research Facility – A facility that is:

- (1) A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
- (2) An NCI-designated Cancer Center; or
- (3) An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

FACT-Accredited Facility

A facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). FACT-accredited cellular therapy programs meet rigorous standards. Information regarding FACT transplant programs can be obtained by contacting the transplant coordinator at the customer service number listed on the back of your ID card or by visiting www.factwebsite.org.

Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

- (1) Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
- (2) Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
- (3) Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
- (4) Services of assistant surgeons;
- (5) Special provider access situations (we encourage you to contact your Local Plan for more information in these types of situations before you receive services from a Non-preferred provider); or
- (6) Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for *Other services* (called prior approval), are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a pre-service claim for benefits (1) requires precertification or prior approval and (2) will result in a reduction of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us. For information about precertification of an emergency inpatient admission, please see page 25.

Warning:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay. (See pages 20-21 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital stay. (See pages 20-21 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

Note: Morbid obesity surgery performed during an inpatient stay (even when Medicare Part A is your primary payor) must meet the surgical requirements described on page 64 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option:

- **Outpatient surgical services** – The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
 - Outpatient surgery for morbid obesity. **Note: Benefits for the surgical treatment of morbid obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed on page 64;**
 - Outpatient surgical correction of congenital anomalies; and
 - Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- **Outpatient intensity-modulated radiation therapy (IMRT)** – Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer. Contact us at the customer service number listed on the back of your ID card before receiving outpatient IMRT for cancers which require prior approval. We will request the medical evidence we need to make our coverage determination.
- **Hospice care** – Contact us at the customer service number listed on the back of your ID card before obtaining home hospice, continuous home hospice, or inpatient hospice care services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 86 for information about the exception to this requirement.
- **Organ/tissue transplants** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants** – See pages 72 and 73 for the list of conditions covered **only** in clinical trials for blood or marrow stem cell transplants. Contact us at the customer service number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 72 and 73, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility (see page 21) where the procedure is to be delivered.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 100 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under **Standard Option**, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. CVS Caremark, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **\$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 23 or is one of the transplant procedures listed on page 23) – even if the charge will be \$5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

How to request precertification for an admission or get prior approval for Other services

First, you, your representative, your physician, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review of the claim and notify you of our decision within 72 hours as long as we receive sufficient information to complete the review. (For concurrent care claims that are also urgent care claims, please see *If your treatment needs to be extended* on page 26.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at the telephone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at the telephone number listed on the back of your ID card. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the request.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone us within two business days, a \$500 penalty may apply – see *Warning under Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* on page 26.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of *Other services*, you may request a review by following the procedures listed below. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 25 for definition). (If you have already received the service, supply, or treatment, then your claim is a **post-service claim** and you must follow the entire disputed claims process detailed in Section 8.)

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, approve your request for prior approval for the service, drug, or supply; or
2. Write to you and maintain our denial; or
3. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Note: You may have to pay the deductible, coinsurance, and/or copayment amount(s) that apply to your care at the time you receive the services.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of \$20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of \$250 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is \$350 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach \$700. For families of two, each family member must fully satisfy his or her individual deductible before this "family deductible" is considered met.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$270) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only**, coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your \$350 calendar year deductible.

If your provider routinely waives your cost

Note: If your provider routinely waives (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges \$100 for a service but routinely waives your 35% Standard Option coinsurance, the actual charge is \$65. We will pay \$42.25 (65% of the actual charge of \$65).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of *Plan allowance* in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. It is possible for a provider's bill to exceed the plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred or Participating and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges \$250, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our \$100 allowance (\$15). Because of the agreement, your Preferred physician will not bill you for the \$150 difference between our allowance and his/her bill.

Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges \$250 for covered services subject to a \$25 copayment. Even though our allowance may be \$100, you still pay just the \$25 copayment. Because of the agreement, your Preferred physician will not bill you for the \$225 difference between your copayment and his/her bill.

Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges \$250, but the Plan allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our \$100 allowance (\$35). Because of the agreement, your Participating physician will not bill you for the \$150 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 21 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our Web site, www.fepblue.org, or call us at the customer service number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pages 145-147). For example, you see a Non-participating physician who charges \$250. The Plan allowance is again \$100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the \$100 Plan allowance or \$35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the \$150 difference between our allowance and his/her bill. This means you would pay a total of \$185 (\$35 + \$150) for the Non-participating physician's services, rather than \$15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 21 for the exceptions to this requirement.

The tables appearing below illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only.**

Basic Option benefit levels for physician care begin on page 37; see page 81 for Basic Option benefit levels that apply to outpatient hospital or ambulatory surgical facility care.

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges \$250 and the Plan allowance is \$100.

EXAMPLE	Preferred Physician Standard Option	Participating Physician Standard Option	Non-participating Physician Standard Option
Physician's charge	\$250	\$250	\$250
Our allowance	We set it at: 100	We set it at: 100	We set it at: 100
We pay	85% of our allowance: 85	65% of our allowance: 65	65% of our allowance: 65
You owe: Coinsurance	15% of our allowance: 15	35% of our allowance: 35	35% of our allowance: 35
You owe: Copayment	Not applicable	Not applicable	Not applicable
+ Difference up to charge?	No: 0	No: 0	Yes: 150
TOTAL YOU PAY	\$15	\$35	\$185

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance (\$100), which you would pay in full, would count toward your deductible.

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges \$5,000. The Plan allowance is \$2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is \$2,500 when the services are provided at a Non-member facility.

EXAMPLE	Preferred Ambulatory Surgical Facility Standard Option	Member Ambulatory Surgical Facility Standard Option	Non-member Ambulatory Surgical Facility* Standard Option
Facility's charge	\$5,000	\$5,000	\$5,000
Our allowance	We set it at: 2,900	We set it at: 2,900	We set it at: 2,500
We pay	85% of our allowance: 2,465	65% of our allowance: 1,885	65% of our allowance: 1,625
You owe: Coinsurance	15% of our allowance: 435	35% of our allowance: 1,015	35% of our allowance: 875
You owe: Copayment	Not applicable	Not applicable	Not applicable
+ Difference up to charge?	No: 0	No: 0	Yes: 2,500
TOTAL YOU PAY	\$435	\$1,015	\$3,375

Note: If you had not met any of your **Standard Option** deductible in the above example, \$350 of our allowed amount would be applied to your deductible before your coinsurance amount was calculated.

***A Non-member facility may bill you any amount for the services it provides. You are responsible for paying all expenses over our allowance, regardless of the total amount billed, in addition to your calendar year deductible and coinsurance. For example, if you use a Non-member facility that charges \$60,000 for facility care related to outpatient bariatric surgery, and we pay the \$1,625 amount illustrated above, you would owe \$58,375 (\$60,000 - \$1,625 = \$58,375). This example assumes your calendar year deductible has been met.**

Important notice about Non-participating providers!

Preferred hospitals may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay 15% of the Non-participating Provider Allowance plus any difference between that allowance and the amount billed (after the member's \$350 calendar year deductible has been satisfied), for services provided in Preferred facilities by Non-participating anesthesiologists (see page 62). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred Provider Allowance after meeting the \$350 calendar year deductible.

In this example, the Non-participating anesthesiologist charges \$1,200 for his/her services. Our Non-participating Provider Allowance for those services is \$400. For the Non-preferred anesthesiologist's services, you would be responsible for paying 15% of the allowance (\$60), plus the \$800 difference between the allowance and the amount billed, for a total of \$860. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the \$400 allowance (after meeting your deductible), or \$60, resulting in a savings to you of \$800 (\$860 - \$60 = \$800).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our Web site, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

Under Basic Option, there are no benefits for care performed by Participating/Member or Non-participating/Non-member providers. You must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

Your costs for other care

- **Overseas care. Under Standard and Basic Options,** we pay overseas claims at Preferred benefit levels. In most cases, our Plan allowance for professional provider services is based on our Overseas Fee Schedule. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care. Under Standard Option,** we pay scheduled amounts for covered dental services and you pay balances as described in Section 5(g). **Under Basic Option,** you pay \$25 for any covered evaluation and we pay the balance for covered services. **Basic Option members** must use **Preferred** dentists in order to receive benefits. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Hospital care. Under Standard and Basic Options,** you pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 21 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

Under Standard and Basic Options, we limit your annual out-of-pocket expenses for the covered services you receive to protect you from unexpected health care costs. When your eligible out-of-pocket expenses reach this catastrophic protection maximum, you no longer have to pay the associated cost-sharing amounts for the rest of the calendar year.

Note: Certain types of expenses do not accumulate to the maximum.

Standard Option maximums:

- **Preferred Provider maximum** - For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is \$5,000 when you use Preferred providers. For a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is \$6,000 for Preferred provider services. Only eligible expenses for Preferred provider services count toward these limits.
- **Non-preferred Provider maximum** - For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is \$7,000 when you use Non-preferred providers. For a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is \$8,000 for Non-preferred provider services. For either enrollment type, eligible expenses for the services of Preferred providers also count toward these limits.

Basic Option maximum:

- **Preferred Provider maximum** - For a Self Only enrollment, your out-of-pocket maximum for eligible coinsurance and copayment amounts, is \$5,500 when you use Preferred providers. For a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is \$7,000 when you use Preferred providers. Only eligible expenses for Preferred provider services count toward these limits.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 29-30;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;

- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The \$500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 21 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 31 and on this page until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 31 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard and Basic Option Benefits

See pages 15-17 for how our benefits changed this year. Pages 153-154 and page 155 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or on our Web site at www.fepblue.org.

Each option offers unique features.

Standard Option

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a \$20 copayment for office visits to primary care providers (\$30 for specialists). Standard Option also features a Preferred Retail Pharmacy Program, a Preferred Mail Service Drug Program, and a Preferred Specialty Drug Pharmacy Program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments (\$25 for primary care providers and \$35 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred Retail Pharmacy Program and a Preferred Specialty Drug Pharmacy Program.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family).
 - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See below and page 21 for the exceptions to this requirement.**
 - We provide benefits at Preferred benefit levels for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	Standard Option	Basic Option
<p>Outpatient professional services of physicians and other health care professionals:</p> <ul style="list-style-type: none">• Consultations• Second surgical opinions• Clinic visits• Office visits• Home visits• Initial examination of a newborn needing definitive treatment when covered under a family enrollment• Pharmacotherapy (medication management) [see Section 5(f) for prescription drug coverage] <p>Note: Please refer to pages 39-40 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a health care professional, and to pages 81-83 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for the visit charge (no deductible)</p> <p>Preferred specialist: \$30 copayment for the visit charge (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient professional services:</p> <ul style="list-style-type: none">• During a hospital stay• Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission• Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits <p>Note: A consulting physician employed by the hospital is not the attending physician.</p> <ul style="list-style-type: none">• Consultations when requested by the attending physician• Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care• Physical therapy by a physician other than the attending physician• Initial examination of a newborn needing definitive treatment when covered under a family enrollment• Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs you receive while in the hospital]• Second surgical opinion• Nutritional counseling when billed by a covered provider	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine services except for those Preventive care services described on pages 41-45 • Telephone consultations and online medical evaluation and management services • Private duty nursing • Standby physicians • Routine radiological and staff consultations required by hospital rules and regulations • Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)] <p>Note: If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.</p>	<i>All charges</i>	<i>All charges</i>

Lab, X-ray, and other diagnostic tests	You Pay	
	Standard Option	Basic Option
<p>Diagnostic tests limited to:</p> <ul style="list-style-type: none"> Laboratory tests (such as blood tests and urinalysis) Pathology services EKGs <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: Nothing</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<p>Diagnostic tests including but not limited to:</p> <ul style="list-style-type: none"> EEGs Neurological testing Ultrasounds X-rays (including set-up of portable X-ray equipment) <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: \$40 copayment</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.</p>

Lab, X-ray, and other diagnostic tests – continued on next page

Lab, X-ray, and other diagnostic tests (continued)	You Pay	
	Standard Option	Basic Option
<p>Diagnostic tests limited to:</p> <ul style="list-style-type: none"> • Bone density tests • CT scans/MRIs/PET scans • Angiographies • Genetic testing <p>Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Diagnostic BRCA testing is covered only for members with a cancer diagnosis. BRCA testing is limited to one test per lifetime whether covered as a diagnostic test or paid under Preventive Care benefits (see page 43).</p> <p>Note: See pages 41, 43, and 44 in this Section for coverage of preventive genetic testing/screening services related to family history of cancer or other disease.</p> <ul style="list-style-type: none"> • Nuclear medicine • Sleep studies <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred: \$100 copayment</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.")</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.</p>

Preventive care, adult	You Pay	
	Standard Option	Basic Option
<p>Benefits are provided for preventive care services for adults age 22 and over, including services recommended under the Affordable Care Act (ACA). For a complete list of preventive care services recommended under the ACA, visit: www.healthcare.gov/what-are-my-preventive-care-benefits. Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) are listed at: http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Visits/exams for preventive care <p>Note: See the definition of <i>Preventive Care, Adult</i> on page 147 for included health screening services.</p> <ul style="list-style-type: none"> • Individual counseling on prevention and reducing health risks <p>Note: Preventive care benefits are not available for group counseling.</p> <p>Note: Preventive care benefits for each of the services listed below are limited to one per calendar year.</p> <ul style="list-style-type: none"> • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • Screening for alcohol/substance abuse <p>Note: See pages 61 and 109 for our coverage of smoking and tobacco cessation treatment.</p> <ul style="list-style-type: none"> • Genetic counseling and evaluation for women whose family history is associated with an increased risk for harmful mutations in BRCA1 or BRCA2 genes <p>Note: Preventive care benefits are available for BRCA testing only as described on page 43.</p> <ul style="list-style-type: none"> • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Papillomavirus (HPV) for females • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection • Administration and interpretation of a Health Risk Assessment (HRA) questionnaire (see <i>Definitions</i>) <p>Note: As a member of the Service Benefit Plan, you have access to the Blue Cross and Blue Shield HRA, called the “Blue Health Assessment” questionnaire. Completing the questionnaire entitles you to receive special benefit incentives. See Section 5(h) for complete information.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for visits/exams for preventive care, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>

Preventive care, adult – continued on next page

Preventive care, adult (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Colorectal cancer tests, including: <ul style="list-style-type: none"> Fecal occult blood test Screening colonoscopy (see page 63 for our payment levels for diagnostic colonoscopies) Sigmoidoscopy Double contrast barium enema Prostate cancer tests – Prostate Specific Antigen (PSA) test Cervical cancer tests (including Pap tests) Screening mammograms Ultrasound for aortic abdominal aneurysm Osteoporosis screening – annual screening for women age 60 and over <p>Note: Preventive care benefits for each of the services listed above are limited to one per calendar year.</p> <ul style="list-style-type: none"> Nutritional counseling when billed by a covered provider <p>Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services.</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers.</p> <p>Note: Benefits are not available for visits/exams for preventive care, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p> <p>Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.</p>

Preventive care, adult – continued on next page

Preventive care, adult (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>BRCA testing for females, age 18 and over, who have not been diagnosed with breast or ovarian cancer, and whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. BRCA testing is limited to one BRCA test per lifetime.</p> <p>Eligible females must meet at least one of the following family history criteria (see note below for females of Ashkenazi Jewish heritage):</p> <ul style="list-style-type: none"> • Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 or younger; or • A combination of three or more first- or second-degree relatives with breast cancer regardless of age at diagnosis; or • A combination of both breast and ovarian cancer among first- and second-degree relatives; or • A first-degree relative with bilateral breast cancer; or • A combination of two or more first- or second-degree relatives with ovarian cancer regardless of age at diagnosis; or • A first- or second-degree relative with both breast and ovarian cancer at any age; or • A history of breast cancer in a male relative <p>Note: The family history criteria listed above do not apply to females of Ashkenazi Jewish heritage. Females of Ashkenazi Jewish heritage must meet one of the following family history criteria:</p> <ul style="list-style-type: none"> • Any first-degree relative with breast or ovarian cancer; or • Two second-degree relatives on the same side of the family with breast or ovarian cancer <p>First-degree relatives are defined as: parents, siblings, and children of the woman being tested. Second-degree relatives are defined as: grandparents, aunts, uncles, nieces, nephews, grandchildren, and half-siblings (siblings with one shared biological parent) of the woman being tested. Relatives may be living or deceased.</p> <p>Note: BRCA testing is limited to one test per lifetime whether paid under Preventive Care benefits or covered as a diagnostic test (see page 40 for our coverage of diagnostic BRCA testing).</p> <p>Note: Preventive care benefits are not available for surgical removal of breasts or ovaries.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. Benefits are not available for BRCA testing performed at Member or Non-member facilities.</p>

Preventive care, adult – continued on next page

Preventive care, adult (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Routine immunizations [as licensed by the U.S. Food and Drug Administration (FDA)], limited to:</p> <ul style="list-style-type: none"> • Hepatitis (Types A and B) for patients with increased risk or family history • Herpes Zoster (shingles)* • Human Papillomavirus (HPV)* • Influenza (flu)* • Measles, Mumps, Rubella • Meningococcal* • Pneumococcal* • Tetanus, Diphtheria, Pertussis booster (one every 10 yrs) • Varicella <p>*Many Preferred retail pharmacies participate in our vaccine network. See page 103 for our coverage of these vaccines when provided by pharmacies in the vaccine network.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: We waive your deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>
<p>Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to certain age ranges, frequencies, and/or other patient-specific indications, including gender.</p> <p>Note: If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.</p> <p>Note: See page 104 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: The benefits listed above and on pages 41-43 do not apply to children up to age 22. (See benefits under <i>Preventive care, children</i>, this Section.)</p>	See above and pages 41-43	See above and pages 41-43
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Genetic testing/screening related to family history of cancer or other disease, except for BRCA testing/screening as described on page 43 <p>Note: See page 40 for our coverage of medically necessary diagnostic genetic testing.</p> <ul style="list-style-type: none"> • Group counseling on prevention and reducing health risks • Self-administered health risk assessments (other than the Blue Health Assessment) • Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans 	All charges	All charges

Preventive care, children	You Pay	
	Standard Option	Basic Option
<p>Benefits are provided for preventive care services for children up to age 22, including services recommended under the Affordable Care Act (ACA), and by the American Academy of Pediatrics (AAP). For a complete list of preventive care services recommended under the ACA, visit: www.healthcare.gov/what-are-my-preventive-care-benefits. Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) are listed at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsab/recs.htm.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Healthy newborn visits and screenings (inpatient or outpatient) • Visits/exams for preventive care • Laboratory tests • Hearing and vision screenings • Routine immunizations as licensed by the U.S. Food and Drug Administration (FDA) limited to: <ul style="list-style-type: none"> Diphtheria, Tetanus, Pertussis Hemophilus Influenza type b (Hib) Hepatitis (Types A and B) Human Papillomavirus (HPV) Inactivated Poliovirus Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Influenza (flu) Varicella <p>Note: U.S. FDA licensure may restrict the use of certain immunizations and vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender.</p> <ul style="list-style-type: none"> • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Papillomavirus (HPV) for females • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection <p>Note: Benefits for sexually transmitted infection (STI) screening tests are limited to one test per STI per year.</p> <ul style="list-style-type: none"> • Nutritional counseling services (see page 42) <p>Note: See page 104 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act.</p> <p>Note: If your child receives both preventive and diagnostic services from a Preferred provider on the same day, you are responsible for paying the cost-share for the diagnostic services.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: We waive the deductible and coinsurance amount for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>

Maternity care	You Pay	
	Standard Option	Basic Option
<p>Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as:</p> <ul style="list-style-type: none"> • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) <p>Note: Maternity care benefits are not provided for oral tocolytic agents. See Section 5(f) for prescription drug coverage (including oral tocolytic agents).</p> <p>Note: Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 59.</p> <ul style="list-style-type: none"> • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant • Breastfeeding education and individual coaching on breastfeeding by medical practitioners such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and registered nurse certified lactation consultants <p>Note: See page 47 for our coverage of breast pump kits.</p> <ul style="list-style-type: none"> • Mental health treatment for postpartum depression and depression during pregnancy <p>Note: We provide benefits to cover up to 4 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage of mental health visits to Non-preferred providers and benefits for additional mental health services.</p> <p>Note: See page 42 for our coverage of nutritional counseling.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be \$5,000 or more. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.</p>	<p>Preferred: Nothing</p> <p>Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to \$175 per admission. For outpatient facility services related to maternity, see page 82.</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.</p>

Maternity care – continued on next page

Maternity care (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. We cover routine nursery care of the newborn child when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of an infant who requires professional services or non-routine treatment, only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: See page 63 for our payment levels for circumcision.</p>		
<ul style="list-style-type: none"> Breast pump kit, limited to one of the two kits listed below, per calendar year for women who are pregnant and/or nursing <ul style="list-style-type: none"> Ameda Manual pump kit or Ameda Double Electric pump kit <p>Note: The breast pump kit will include a supply of 150 Ameda milk storage bags. You may order Ameda milk storage bags, limited to 150 bags every 90 days, even if you own your own breast pump.</p> <p>Note: Benefits for the breast pump kit and milk storage bags are only available when you order them through CVS Caremark by calling 1-800-262-7890.</p>	Nothing (no deductible)	Nothing

Maternity care – continued on next page

Maternity care (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest • Genetic testing/screening of the baby's father (see page 40 for our coverage of medically necessary diagnostic genetic testing) • Childbirth preparation, Lamaze, and other birthing/parenting classes • Breast pumps and milk storage bags except as stated on page 47 • Breastfeeding supplies other than those contained in the breast pump kit described on page 47 including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads) • Maternity care for women not enrolled in this Plan 	All charges	All charges
Family planning		
<p>A range of voluntary family planning services for women, limited to:</p> <ul style="list-style-type: none"> • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Voluntary sterilization (tubal ligation or tubal occlusion/tubal blocking procedures only) <p>Note: See page 63 for our coverage of voluntary sterilization for men.</p> <p>Note: We also provide benefits for professional services associated with voluntary sterilizations and with the fitting, insertion, implantation, or removal of the contraceptives listed above at the payment levels shown here.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Family planning – continued on next page

Family planning (continued)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Oral and transdermal contraceptives <p>Note: We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. See page 102 for more information.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Reversal of voluntary surgical sterilization Contraceptive devices not described above Over-the-counter (OTC) contraceptives, except as described in Section 5(f) 	<i>All charges</i>	<i>All charges</i>
Infertility services		
<p>Diagnosis and treatment of infertility, except as shown in <i>Not covered</i></p> <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

Infertility services – continued on next page

Infertility services (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to: <ul style="list-style-type: none"> – Artificial insemination (AI) – In vitro fertilization (IVF) – Embryo transfer and Gamete Intrafallopian Transfer (GIFT) – Zygote Intrafallopian Transfer (ZIFT) – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intracytoplasmic sperm injection (ICSI) – Intrauterine insemination (IUI) • Services and supplies related to ART and assisted insemination procedures • Cryopreservation or storage of sperm (sperm banking), eggs, or embryos • Infertility drugs used in conjunction with ART and assisted insemination procedures • Services, supplies, or drugs provided to individuals not enrolled in this Plan 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit; nothing for injections</p> <p>Preferred specialist: \$35 copayment per visit; nothing for injections</p> <p>Participating/Non-participating: You pay all charges (except as noted below)</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>

Treatment therapies	You Pay	
	Standard Option	Basic Option
<p>Outpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy <i>Note:</i> We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under <i>Organ/tissue transplants</i> in Section 5(b). See also, <i>Other services</i> under <i>You need prior Plan approval for certain services</i> in Section 3 (pages 23-24). Intensity-modulated radiation therapy (IMRT) <i>Note:</i> You must get prior approval for outpatient IMRT related to cancers other than head, neck, breast, or prostate cancer. Please refer to page 23 for more information. Renal dialysis – Hemodialysis and peritoneal dialysis Intravenous (IV)/infusion therapy – Home IV or infusion therapy <i>Note:</i> Home nursing visits associated with Home IV/infusion therapy are covered as shown under <i>Home health services</i> on page 59. Outpatient cardiac rehabilitation <p><i>Note:</i> See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.</p> <p><i>Note:</i> See page 60 for our coverage of osteopathic and chiropractic manipulative treatment.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p><i>Note:</i> You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient treatment therapies:</p> <ul style="list-style-type: none"> Chemotherapy and radiation therapy <i>Note:</i> We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under <i>Organ/tissue transplants</i> in Section 5(b). See also, <i>Other services</i> under <i>You need prior Plan approval for certain services</i> in Section 3 (pages 23-24). Renal dialysis – Hemodialysis and peritoneal dialysis Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies] 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Physical therapy, occupational therapy, speech therapy, and cognitive therapy	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech therapy Cognitive rehabilitation therapy <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit (no deductible)</p> <p>Preferred specialist: \$30 copayment per visit (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay Maintenance or palliative rehabilitative therapy Exercise programs Hippotherapy (exercise on horseback) Massage therapy 	<i>All charges</i>	<i>All charges</i>

Hearing services (testing, treatment, and supplies)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Hearing tests related to illness or injury Testing and examinations for prescribing hearing aids <p>Note: For our coverage of hearing aids and related services, see page 56.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Routine hearing tests (except as indicated on page 45) Hearing aids (except as described on page 56) 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<p>Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed:</p> <ul style="list-style-type: none"> To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition; For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 <p>Note: Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>

Vision services (testing, treatment, and supplies) – continued on next page

Vision services (testing, treatment, and supplies) (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> • Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 <p>Note: See page 53 for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus.</p> <p>Note: See Section 5(b), <i>Surgical procedures</i>, for coverage for surgical treatment of amblyopia and strabismus.</p> <p>Note: See pages 39-40 in this Section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider. Benefits are not available for refractions except as described on page 53.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment (no deductible)</p> <p>Preferred specialist: \$30 copayment (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 53</i> • <i>Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.</i> • <i>Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom</i> • <i>Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above</i> • <i>LASIK, INTACS, radial keratotomy, and other refractive surgical services</i> • <i>Refractions, including those performed during an eye examination related to a specific medical condition, except as described on page 53</i> 	<i>All charges</i>	<i>All charges</i>

Foot care	You Pay	
	Standard Option	Basic Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p> <p>Note: See Section 5(b) for our coverage for surgical procedures.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies)</p> <p>Preferred specialist: \$30 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Orthopedic and prosthetic devices		
<p>Orthopedic braces and prosthetic appliances such as:</p> <ul style="list-style-type: none"> Artificial limbs and eyes Functional foot orthotics when prescribed by a physician Rigid devices attached to the foot or a brace, or placed in a shoe Replacement, repair, and adjustment of covered devices Following a mastectomy, breast prostheses and surgical bras, including necessary replacements Surgically implanted penile prostheses to treat erectile dysfunction <p>Note: A prosthetic appliance is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.</p> <p>We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>

Orthopedic and prosthetic devices – continued on next page

Orthopedic and prosthetic devices (continued)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Hearing aids for children up to age 22, limited to \$2,500 per calendar year Hearing aids for adults age 22 and over, limited to \$2,500 every 3 calendar years <p>Note: Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.</p>	Any amount over \$2,500 (no deductible)	Any amount over \$2,500
<ul style="list-style-type: none"> Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to \$5,000 per calendar year 	Any amount over \$5,000 (no deductible)	Any amount over \$5,000
<ul style="list-style-type: none"> Wigs for hair loss due to the treatment of cancer <p>Note: Benefits for wigs are paid at 100% of the billed amount, limited to \$350 for one wig per lifetime.</p>	Any amount over \$350 for one wig per lifetime (no deductible)	Any amount over \$350 for one wig per lifetime
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Shoes (including diabetic shoes)</i> <i>Over-the-counter orthotics</i> <i>Arch supports</i> <i>Heel pads and heel cups</i> <i>Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to the treatment of cancer, as stated above</i> <i>Hearing aid accessories or supplies (including remote controls and warranty packages)</i> 	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME)	You Pay	
	Standard Option	Basic Option
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Continuous passive motion (CPM) devices • Dynamic orthotic cranioplasty (DOC) devices • Insulin pumps • Other items that we determine to be DME, such as compression stockings <p>Note: We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>
<ul style="list-style-type: none"> • Speech-generating devices, limited to \$1,250 per calendar year 	Any amount over \$1,250 per year (no deductible)	Any amount over \$1,250 per year

Durable medical equipment (DME) – continued on next page

Durable medical equipment (DME) (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <p><i>Exercise and bathroom equipment</i></p> <p><i>Lifts, such as seat, chair, or van lifts</i></p> <p><i>Car seats</i></p> <p><i>Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary</i></p> <p><i>Air conditioners, humidifiers, dehumidifiers, and purifiers</i></p> <p><i>Breast pumps, except as described on page 47</i></p> <p><i>Communications equipment, devices, and aids (including computer equipment) such as “story boards” or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed on page 57)</i></p> <p><i>Equipment for cosmetic purposes</i></p> <p><i>Topical Hyperbaric Oxygen Therapy (THBO)</i></p>	<i>All charges</i>	<i>All charges</i>
Medical supplies		
<ul style="list-style-type: none"> Medical foods for children with inborn errors of amino acid metabolism Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) <p>Note: See Section 10, <i>Definitions</i>, for more information about medical foods.</p> <ul style="list-style-type: none"> Ostomy and catheter supplies Oxygen <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility.</p> <ul style="list-style-type: none"> Blood and blood plasma, except when donated or replaced, and blood plasma expanders <p>Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Infant formulas used as a substitute for breastfeeding</i> <p><i>Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary</i></p>	<i>All charges</i>	<i>All charges</i>

Home health services	You Pay	
	Standard Option	Basic Option
<p>Home nursing care for two (2) hours per day when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Benefits for home nursing care are limited to 50 visits per person, per calendar year.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Note: Benefits for home nursing care are limited to 25 visits per person, per calendar year.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient’s family</i> • <i>Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter</i> • <i>Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home, except as included in the benefits described on page 85</i> • <i>Private duty nursing</i> 	<i>All charges</i>	<i>All charges</i>

Manipulative treatment	You Pay	
	Standard Option	Basic Option
<p>Manipulative treatment performed by a Doctor of Osteopathy (D.O.), Doctor of Medicine (M.D.), or Doctor of Chiropractic (D.C.) when the provider is practicing within the scope of his/her license, limited to:</p> <ul style="list-style-type: none"> Osteopathic manipulative treatment to any body region Chiropractic spinal and/or extraspinal manipulative treatment <p>Note: Benefits for manipulative treatment are limited to the services and combined treatment visits stated here.</p>	<p>Preferred: \$20 copayment per visit (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 12 visits per person, per calendar year.</p> <p>Note: Manipulation visits that you pay for while meeting your calendar year deductible count toward the treatment limit cited above.</p>	<p>Preferred: \$25 copayment per visit</p> <p>Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 visits per person, per calendar year.</p> <p>Participating/Non-participating: You pay all charges</p>
Alternative treatments		
<p>Acupuncture</p> <p>Note: Acupuncture must be performed and billed by a medical practitioner who is licensed or certified to perform acupuncture by the state where the services are provided, and who is acting within the scope of that license or certification. See page 18 for more information.</p> <p>Note: See page 76 for our coverage of acupuncture when provided as anesthesia for covered surgery.</p> <p>Note: See page 46 for our coverage of acupuncture when provided as anesthesia for covered maternity care.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Benefits for acupuncture are limited to 24 visits per calendar year.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Note: Benefits for acupuncture are limited to 10 visits per calendar year.</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Biofeedback Self-care or self-help training 	<i>All charges</i>	<i>All charges</i>

Educational classes and programs	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Smoking and tobacco cessation treatment Individual counseling for smoking and tobacco use cessation <i>Note:</i> Benefits are not available for group counseling. Smoking and tobacco cessation classes <i>Note:</i> See Section 5(f) for our coverage of smoking and tobacco cessation drugs. 	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> Diabetic education <i>Note:</i> See pages 42 and 45 for our coverage of nutritional counseling services that are not part of a diabetic education program. 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$25 copayment per visit</p> <p>Preferred specialist: \$35 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Marital, family, educational, or other counseling or training services when performed as part of an educational class or program Premenstrual syndrome (PMS), lactation (except as described on page 46), headache, eating disorder (except as described on pages 42 and 45), and other educational clinics Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay Services performed or billed by a school or halfway house or a member of its staff Applied behavior analysis (ABA) or ABA therapy 	<i>All charges</i>	<i>All charges</i>

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 23 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family).
 - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.
 - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **\$5,000 or more**. See page 24 for more information.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits. See below and page 21 for the exceptions to this requirement.**
 - We provide benefits at Preferred benefit levels for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Surgical procedures	Standard Option	Basic Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none">• Operative procedures• Treatment of fractures and dislocations, including casting• Normal pre- and post-operative care by the surgeon• Correction of amblyopia and strabismus• Colonoscopy (with or without biopsy) to diagnose or treat a specific condition <p>Note: See page 42 for our coverage of screening colonoscopies billed for by a physician or other covered health care professional.</p> <ul style="list-style-type: none">• Endoscopic procedures• Injections• Biopsy procedures• Removal of tumors and cysts• Correction of congenital anomalies (see <i>Reconstructive surgery</i> on page 66)• Treatment of burns• Circumcision of newborn• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device.• Voluntary sterilization for men (vasectomy) <p>Note: See page 48 for our coverage of voluntary sterilization procedures for women.</p> <ul style="list-style-type: none">• Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures• Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with one or more co-morbidities; eligible members must be age 18 or over <p>Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on page 64.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 24 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>

Surgical procedures – continued on next page

Surgical procedures (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Note: Prior approval is required for outpatient surgery for morbid obesity. For more information about prior approval, please refer to page 23.</p> <ul style="list-style-type: none"> • Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. The member must meet all requirements. <ul style="list-style-type: none"> – Diagnosis of morbid obesity (as defined on page 63) for a period of 2 years prior to surgery – Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery. (Note: Benefits are not available for commercial weight loss programs; see page 42 for our coverage of nutritional counseling services.) – Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise – Evidence that attempts at weight loss in the 1 year period prior to surgery have been ineffective – Psychological clearance of the member's ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner (see page 95 for our payment levels for mental health services) – Member has not smoked in the 6 months prior to surgery – Member has not been treated for substance abuse for 1 year prior to surgery and there is no evidence of substance abuse during the 1-year period prior to surgery • Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements: <ul style="list-style-type: none"> – All criteria listed above for the initial procedure must be met again – Previous surgery for morbid obesity was at least 2 years prior to repeat procedure – Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure – Member complied with previously prescribed post-operative nutrition and exercise program • Claims for the surgical treatment of morbid obesity must include documentation from the member's provider(s) that all pre-surgical requirements have been met. 		

Surgical procedures – continued on next page

Surgical procedures (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure.</p> <p>Note: We do not pay extra for “incidental” procedures (those that do not add time or complexity to patient care).</p> <p>Note: When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby physician</i> • <i>Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]</i> • <i>Cosmetic surgery</i> • <i>LASIK, INTACS, radial keratotomy, and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>

Reconstructive surgery	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. <p>Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.</p> <p>Note: You must get prior approval for outpatient surgical correction of congenital anomalies. Please refer to page 23 for more information.</p> <ul style="list-style-type: none"> Treatment to restore the mouth to a pre-cancer state All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> Surgery to produce a symmetrical appearance of the patient's breasts Treatment of any physical complications, such as lymphedemas <p>Note: Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility.</p> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> Surgery for placement of penile prostheses to treat erectile dysfunction 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 24 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.")</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)</i> <i>Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown above</i> 	<i>All charges</i>	<i>All charges</i>

Oral and maxillofacial surgery	You Pay	
	Standard Option	Basic Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary Surgery needed to correct accidental injuries (see <i>Definitions</i>) to jaws, cheeks, lips, tongue, roof and floor of mouth <p>Note: You must get prior approval for outpatient surgery needed to correct accidental injuries as described above. Please refer to page 23 for more information.</p> <ul style="list-style-type: none"> Excision of exostoses of jaws and hard palate Incision and drainage of abscesses and cellulitis Incision and surgical treatment of accessory sinuses, salivary glands, or ducts Reduction of dislocations and excision of temporomandibular joints Removal of impacted teeth <p>Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 24 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g) Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g) Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g) Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g) 	<i>All charges</i>	<i>All charges</i>

Organ/tissue transplants	You Pay	
	Standard Option	Basic Option
<p>Solid organ transplants (see list in the next box below) are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 (see page 23) for prior approval procedures.</p> <p>Prior approval requirements:</p> <p>You must obtain prior approval (see page 23) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:</p> <ul style="list-style-type: none"> Blood or marrow stem cell transplant procedures <i>Note:</i> See pages 72 and 73 for services related to blood or marrow stem cell transplants covered under clinical trials. Autologous pancreas islet cell transplant Heart Heart-lung Intestinal transplants (small intestine with or without other organs) Liver Lung (single, double, or lobar) Pancreas Simultaneous liver-kidney Simultaneous pancreas-kidney <p><i>Note:</i> Refer to pages 24-25 for information about precertification of inpatient care.</p>		
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> Cornea Heart Heart-lung Simultaneous pancreas-kidney Simultaneous liver-kidney Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Single, double, or lobar lung For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p><i>Note:</i> You may request prior approval and receive specific benefit information in advance for kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be \$5,000 or more. See page 24 for more information.</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p><i>Note:</i> Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p><i>Note:</i> If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Physicians consider many features to determine how diseases will respond to different types of treatments. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Myeloablative allogeneic blood or marrow stem cell transplants for: <ul style="list-style-type: none"> – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Chronic myelogenous leukemia – Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) – High-risk neuroblastoma – Hodgkin's lymphoma – Infantile malignant osteopetrosis – Inherited metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – Marrow failure [i.e., severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] – MDS/MPN [e.g., Chronic myelomonocytic leukemia (CMML)] – Myelodysplasia/Myelodysplastic syndromes (MDS) – Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) – Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Primary Immunodeficiencies (e.g., Severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies) 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (<i>continued from page 69</i>). For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Myeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan. <ul style="list-style-type: none"> – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan. <ul style="list-style-type: none"> – Acute non-lymphocytic (myelogenous) leukemia/acute lymphocytic leukemia – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with poor response to therapy; short time to progression; transformed disease; or high risk disease – Chronic myelogenous leukemia – Hemoglobinopathy (Sickle-cell anemia, Thalassemia major) – Hodgkin's lymphoma – Infantile malignant osteopetrosis – Inherited Metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – Marrow failure [severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] – MDS/MPN [e.g., chronic myelomonocytic leukemia (CMML)] – Myelodysplasia/myelodysplastic syndromes (MDS) 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (<i>continued from page 70</i>). For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, only when performed in a Blue Distinction Centers for Transplants facility. You must obtain prior approval of these transplant procedures from the Local Plan (<i>continued from page 70</i>). <ul style="list-style-type: none"> – Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) – Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] – Primary Immunodeficiencies (Severe combined immunodeficiency, Wiskott-Aldrich syndrome, Hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies) • Autologous blood or marrow stem cell transplants for: <ul style="list-style-type: none"> – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Central Nervous System (CNS) Embryonal tumors [e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma] – Ewing's sarcoma – Germ cell tumors – High-risk neuroblastoma – Hodgkin's lymphoma – Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>(1) For the following blood or marrow stem cell transplant procedures, we provide benefits only when conducted at a Cancer Research Facility, a Blue Distinction Centers for Transplants facility, or a Foundation for the Accreditation of Cellular Therapy (FACT) accredited facility (see pages 20 and 21) and only when performed as part of a clinical trial that meets the requirements listed on page 73:</p> <p>Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> – Breast cancer – Colon cancer – Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) – Epidermolysis bullosa – Ovarian cancer – Prostate cancer – Renal cell carcinoma – Retinoblastoma – Rhabdomyosarcoma – Sarcoma – Wilm's Tumor <p>Autologous blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> – Breast cancer – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Chronic myelogenous leukemia – Epithelial ovarian cancer – Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) – Retinoblastoma – Rhabdomyosarcoma – Wilm's Tumor <p>Note: If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the requirements shown on page 73 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>(2) For the following procedures, we provide benefits only when conducted at a FACT-accredited facility (see page 21) and only when performed as part of a clinical trial that meets the requirements listed below:</p> <p>Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants or autologous blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> – Autoimmune disease (e.g., Multiple sclerosis, Scleroderma, Systemic lupus erythematosus, Chronic inflammatory demyelinating polyneuropathy) <p>(3) Requirements for blood or marrow stem cell transplants covered under clinical trials:</p> <p>For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials:</p> <ul style="list-style-type: none"> • You must contact us at the customer service number listed on the back of your ID card to obtain prior approval (see page 23); • The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. <p>Note: Clinical trials are research studies in which physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. A clinical trial has possible benefits as well as risks. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial. Information regarding clinical trials is available at www.cancer.gov.</p> <p>Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Cancer Research Facility or FACT-accredited facility to treat your condition at the time you seek to be included in a clinical trial. If your physician has recommended you participate in a clinical trial, we encourage you to contact the Case Management Department at your Local Plan for assistance.</p> <p>Note: See page 134 for our coverage of other costs associated with clinical trials.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Related transplant services:</p> <ul style="list-style-type: none"> Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 69-73 <p>Note: Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells.</p> <ul style="list-style-type: none"> Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 69-73 Related medical and hospital expenses of the donor, when we cover the recipient Related services or supplies provided to the recipient Donor screening tests for up to three non-full sibling (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for transplant <p>Note: See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$150 copayment per performing surgeon, for surgical procedures performed in an office setting</p> <p>Preferred: \$200 copayment per performing surgeon, for surgical procedures performed in all other settings</p> <p>Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.</p> <p>Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)***Organ/Tissue Transplants at Blue Distinction Centers for Transplants®**

We participate in the Blue Distinction Centers for Transplants program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility (see pages 20-21 for more information).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Liver
- Pancreas (pancreas transplant alone, pancreas after kidney, simultaneous pancreas-kidney)
- Single or double lung
- Blood or marrow stem cell transplants listed on pages 69-73
- Related transplant services listed on page 74

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 68 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see pages 20-21).

Note: See pages 69-74 for requirements related to blood or marrow stem cell transplant coverage.

Note: See pages 20-21 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Transplants for any diagnosis not listed as covered</i> • <i>Donor screening tests and donor search expenses, except as defined on page 74</i> • <i>Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy</i> 	<i>All charges</i>	<i>All charges</i>

Anesthesia	You Pay	
	Standard Option	Basic Option
<p>Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by:</p> <ul style="list-style-type: none"> • A certified registered nurse anesthetist (CRNA), or • A physician other than the physician (or the assistant) performing the covered medical or surgical procedure <p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness.</p> <p>Note: See Section 5(c) for our payment levels for anesthesia services billed by a facility.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- **Note: Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 81. See page 145 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 23 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family).
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits.** See page 21 for the exceptions to this requirement.
 - Your cost-share for care performed and billed by Preferred professional providers in the outpatient department of a Preferred hospital is waived for services other than surgical services, drugs, supplies, orthopedic and prosthetic devices, and durable medical equipment. You are responsible for the applicable cost-sharing amount(s) for the services performed and billed by the hospital.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Inpatient hospital	Standard Option	Basic Option
<p>Room and board, such as:</p> <ul style="list-style-type: none">• Semiprivate or intensive care accommodations• General nursing care• Meals and special diets <p>Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 145 for more information.</p>	<p>Preferred: \$250 per admission copayment for unlimited days (no deductible)</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment</p> <p>Note: If you are admitted to a Member or Non-member facility due to a medical emergency or accidental injury, you pay a \$350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.</p>	<p>Preferred: \$175 per day copayment up to \$875 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital – continued on next page

Inpatient hospital (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic studies, radiology services, laboratory tests, and pathology services • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation <p>Note: Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 81. See page 145 for more information about these types of services.</p> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). <p>Note: See pages 46-47 for other covered maternity services.</p> <p>Note: See page 58 for coverage of blood and blood products.</p>	<p>Preferred: \$250 per admission copayment for unlimited days (no deductible)</p> <p>Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility.</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment</p>	<p>Preferred: \$175 per day copayment up to \$875 per admission for unlimited days</p> <p>Note: For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to \$175 per admission.</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital – continued on next page

Inpatient hospital (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers • Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services • Private duty nursing <p><i>Hospital room and board expenses when, in our judgment, a hospital admission or portion of an admission is:</i></p> <ul style="list-style-type: none"> • Custodial or long term care (see Definitions) • Convalescent care or a rest cure • Domiciliary care provided because care in the home is not available or is unsuitable • Not medically necessary, such as when services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are: <ul style="list-style-type: none"> – Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office) – Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office) <p>Note: If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers (see pages 18-21).</p>	<i>All charges</i>	<i>All charges</i>

Outpatient hospital or ambulatory surgical center	You Pay	
	Standard Option	Basic Option
<p>Outpatient surgical and treatment services performed and billed by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Observation services <p>Note: Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on this page. See page 145 for more information about these types of services.</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy • Colonoscopy (with or without biopsy) to diagnose or treat a specific condition <p>Note: See page 42 for our coverage of screening colonoscopies.</p> <ul style="list-style-type: none"> • Intravenous (IV)/infusion therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency treatment services • Diabetic education • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Facility supplies for hemophilia home care • Other medical supplies, including oxygen <p>Note: See pages 90-93 for our payment levels for care related to a medical emergency or accidental injury.</p> <p>Note: See pages 48-49 for our coverage of family planning services.</p> <p>Note: For our coverage of hospital-based clinic visits, please refer to the professional benefits described on page 37.</p>	<p>Preferred facilities: 15% of the Plan allowance (deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$100 copayment per day per facility (except as noted below)</p> <p>Note: You may be responsible for paying a \$150 copayment per day per facility if other diagnostic services are billed in addition to the services listed here.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Member/Non-member: You pay all charges</p>

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. See pages 46-47 for other included maternity services.</p> <p>Note: See page 84 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility.</p> <p>Note: We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries.</p> <p>We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), <i>Dental benefits</i>, for additional benefit information.</p>		
<p>Outpatient diagnostic testing and treatment services performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <ul style="list-style-type: none"> • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Genetic testing • Nuclear medicine • Sleep studies 	<p>Preferred facilities: 15% of the Plan allowance (deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$150 copayment per day per facility</p> <p>Member: \$150 copayment per day per facility</p> <p>Non-member: \$150 copayment per day per facility, plus any difference between our allowance and the billed amount</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p>
<p>Outpatient diagnostic testing services performed and billed by a hospital or freestanding ambulatory facility, including but not limited to:</p> <ul style="list-style-type: none"> • EEGs • Ultrasounds • Neurological testing • X-rays (including set-up of portable X-ray equipment) <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p>	<p>Preferred facilities: 15% of the Plan allowance (deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$40 copayment per day per facility</p> <p>Member: \$40 copayment per day per facility</p> <p>Non-member: \$40 copayment per day per facility, plus any difference between our allowance and the billed amount</p> <p>Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p>

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Outpatient treatment services performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <p>Cardiac rehabilitation</p> <p>Cognitive rehabilitation</p> <p>Pulmonary rehabilitation</p> <p>Physical, occupational, and speech therapy</p>	<p>Preferred facilities: 15% of the Plan allowance (deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: See page 52 for our coverage of physical, occupational, and speech therapy.</p>	<p>Preferred: \$25 copayment per day per facility</p> <p>Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p> <p>Note: Benefits are limited to a total of 50 visits per person, per calendar year for outpatient physical, occupational, or speech therapy, or a combination of all three, regardless of the type of covered provider billing for the services.</p> <p>Member/Non-member: You pay all charges</p>
<p>Outpatient diagnostic and treatment services performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <ul style="list-style-type: none"> Laboratory tests and pathology services EKGs <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p>	<p>Preferred facilities: 15% of the Plan allowance (deductible applies)</p> <p>Member facilities: 35% of the Plan allowance (deductible applies)</p> <p>Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: Nothing</p> <p>Member: Nothing</p> <p>Non-member: You pay any difference between our allowance and the billed amount</p> <p>Note: You may be responsible for paying a copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.</p> <p>Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about “agents.”)</p>

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center <i>(continued)</i>	You Pay	
	Standard Option	Basic Option
<p>Outpatient adult preventive care performed and billed by a hospital or freestanding ambulatory facility, limited to:</p> <ul style="list-style-type: none"> • Visits/exams for preventive care and screening procedures described on pages 41-44 • Cancer screenings listed on page 42 and ultrasound screening for aortic abdominal aneurysm <p>Note: See page 45 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.</p>	<p>See pages 41-44 for our payment levels for covered preventive care services for adults</p>	<p>Preferred: Nothing</p> <p>Note: See page 41 for our payment levels for visits/exams for preventive care.</p> <p>Member/Non-member: Nothing for cancer screenings and ultrasound screening for aortic abdominal aneurysm</p> <p>Note: Benefits are not available for routine adult physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.</p>
<p>Outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment <p>Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.</p>	<p>Preferred facilities: 15% of the Plan allowance (deductible applies)</p> <p>Member/Non-member facilities: 35% of the Plan allowance (deductible applies)</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Note: You may also be responsible for paying a copayment per day per facility for outpatient services. See above and pages 81-83 for specific coverage information.</p> <p>Member/Non-member: You pay all charges</p>

Extended care benefits/Skilled nursing care facility benefits	You Pay	
	Standard Option	Basic Option
<p>Limited to the following benefits for Medicare Part A copayments:</p> <p>When Medicare Part A is the primary payor (meaning that it pays first) and has made payment, Standard Option provides limited secondary benefits.</p> <p>We pay the applicable Medicare Part A copayments incurred in full during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases.</p> <p>If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day.</p> <p>Note: See page 52 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs.</p> <p>Note: If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating/Member: Nothing (no deductible)</p> <p>Non-participating/Non-member: Nothing (no deductible)</p> <p>Note: You pay all charges not paid by Medicare after the 30th day.</p>	<p><i>All charges</i></p>

Hospice care	You Pay	
	Standard Option	Basic Option
<p>Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six (6) months or less due to a terminal medical condition, as certified by the member's primary care provider or specialist.</p>	See below and pages 87-88	See below and pages 87-88
<p>Pre-Hospice Enrollment Benefits</p> <p>Prior approval is not required.</p> <p>Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as:</p> <ul style="list-style-type: none"> • Evaluating the member's need for pain and/or symptom management; and • Counseling regarding hospice and other care options 	Nothing (no deductible)	Nothing
<p>Prior approval from the Local Plan is required for all hospice services. Our prior approval decision will be based on the medical necessity of the hospice treatment plan and the clinical information provided to us by the primary care provider (or specialist) and the hospice provider. We may also request information from other providers who have treated the member. All hospice services must be billed by the approved hospice agency. You are responsible for making sure the hospice care provider has received prior approval from the Local Plan (see page 23 for instructions). Please check with your Local Plan, and/or go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, for listings of Preferred hospice providers.</p> <p>Note: If Medicare Part A is the primary payor for the member's hospice care, prior approval is not required. However, our benefits will be limited to those services listed above and on pages 87 and 88.</p> <p>Members with a terminal medical condition (or those acting on behalf of the member) are encouraged to contact the Case Management Department at their Local Plan for information about hospice services and Preferred hospice providers.</p>		

Hospice care – continued on next page

Hospice care (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
Covered services <p>We provide benefits for the hospice services listed below when the services have been included in an approved hospice treatment plan and are provided by the home hospice program in which the member is enrolled:</p> <ul style="list-style-type: none"> • Nursing care • Periodic physician visits • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Oxygen therapy • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency) 	See below	See below
Traditional Home Hospice Care <p>Periodic visits to the member's home for the management of the terminal medical condition and to provide limited patient care in the home. See page 86 for prior approval requirements.</p>	Nothing (no deductible)	Nothing
Continuous Home Hospice Care <p>Services provided in the home to members enrolled in home hospice during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member's condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).</p> <p>Note: Members must receive prior approval from the Local Plan for each episode of continuous home hospice care (see page 86). An episode consists of up to seven (7) consecutive days of continuous care. Each episode must be separated by at least 21 days of traditional home hospice care. The member must be enrolled in a home hospice program and the continuous home hospice care services must be provided by the home hospice program in which the member is enrolled.</p>	<p>Preferred: \$250 per episode copayment (no deductible)</p> <p>Member: \$350 per episode copayment (no deductible)</p> <p>Non-member: \$350 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment</p>	<p>Preferred: \$150 per day copayment up to \$750 maximum per episode</p> <p>Member/Non-member: You pay all charges</p>

Hospice care – continued on next page

Hospice care (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Inpatient Hospice Care</p> <p>Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when:</p> <ul style="list-style-type: none"> • Inpatient services are necessary to control pain and/or manage the member's symptoms; • Death is imminent; or • Inpatient services are necessary to provide an interval of relief (respite) to the caregiver <p>Note: Benefits are provided for up to thirty (30) consecutive days in a facility licensed as an inpatient hospice facility. Each inpatient stay must be separated by at least 21 days of traditional home hospice care. The member does not have to be enrolled in a home hospice care program to be eligible for the first inpatient stay. However, the member must be enrolled in a home hospice care program in order to receive benefits for subsequent inpatient stays.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Member: \$350 per admission copayment, plus 35% of the Plan allowance (no deductible)</p> <p>Non-member: \$350 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment</p>	<p>Preferred: Nothing</p> <p>Member/Non-member: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Homemaker services</i> • <i>Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Ambulance	You Pay	
	Standard Option	Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services (no deductible)</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services (no deductible)</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p> <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating/Member or Non-participating/Non-member: Nothing (no deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Wheelchair van services and gurney van services</i> • <i>Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family).
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Accidental injury	Standard Option	Basic Option
<ul style="list-style-type: none">• Physician services in the hospital outpatient department, urgent care center, or physician’s office, including diagnostic studies, radiology services, laboratory tests, and pathology services• Related outpatient hospital services and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services <p>Note: We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: See Section 5(g) for dental benefits for accidental injuries.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating/Member: Nothing (no deductible)</p> <p>Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (no deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p> <p>Note: For drugs, services, supplies, and/or durable medical equipment billed by a provider other than a hospital, urgent care center, or physician, see Sections 5(a) and 5(f) for the benefit levels that apply.</p>	<p>Preferred urgent care center: \$50 copayment per visit</p> <p>Participating/Non-participating urgent care center: You pay all charges</p> <p>Preferred emergency room: \$125 copayment per visit</p> <p>Participating/Member emergency room: \$125 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$125 copayment per visit, plus any difference between our allowance and the billed amount</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$125 emergency room copayment. However, the \$175 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p> <p>Note: Regular benefit levels apply to covered services provided in settings other than an emergency room or urgent care center. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none">• <i>Oral surgery except as shown in Section 5(b)</i>• <i>Injury to the teeth while eating</i>• <i>Emergency room professional charges for shift differentials</i>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Medical emergency	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> • Physician services including diagnostic studies, radiology services, laboratory tests, and pathology services • Related outpatient hospital services and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services <p>Note: We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: Please refer to Section 3 for information about precertifying emergency hospital admissions.</p> <p>Note: Regular benefit levels apply to covered services provided in settings other than an emergency room or urgent care center. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p>	<p>Preferred urgent care center: \$40 copayment per visit (no deductible)</p> <p>Participating urgent care center: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating urgent care center: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Preferred emergency room: 15% of the Plan allowance (deductible applies)</p> <p>Participating/Member emergency room: 15% of the Plan allowance (deductible applies)</p> <p>Non-participating/Non-member emergency room: 15% of the Plan allowance (deductible applies). If you use a Non-participating provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: These benefit levels do not apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on page 91 for the benefits we provide.</p>	<p>Preferred urgent care center: \$50 copayment per visit</p> <p>Participating/Non-participating urgent care center: You pay all charges</p> <p>Preferred emergency room: \$125 copayment per visit</p> <p>Participating/Member emergency room: \$125 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$125 copayment per visit, plus any difference between our allowance and the billed amount</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$125 emergency room copayment. However, the \$175 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>
<i>Not covered: Emergency room professional charges for shift differentials</i>	<i>All charges</i>	<i>All charges</i>

Ambulance	You Pay	
	Standard Option	Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p> <p>Note: See Section 5(c) for non-emergency ambulance services.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services (no deductible)</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services (no deductible)</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day (no deductible).</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p> <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p>	<p>Preferred: Nothing (no deductible)</p> <p>Participating/Member or Non-participating/Non-member: Nothing (no deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$100 copayment per day for ground ambulance transport services</p> <p>Participating/Member or Non-participating/Non-member: \$100 copayment per day for ground ambulance transport services</p> <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Wheelchair van services and gurney van services</i> • <i>Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(e). Mental health and substance abuse benefits**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you have a chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to pages 120 and 141. Contact us at the telephone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your health care needs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
 - The calendar year deductible is \$350 per person (\$700 per family).
 - You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
 - **You must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.**
 - There is **no calendar year deductible**.

Benefit Description		You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.			
Professional services	Standard Option	Basic Option	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	

Professional services – continued on next page

Professional services (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Services provided by licensed professional mental health and substance abuse practitioners when acting within the scope of their license</p> <ul style="list-style-type: none"> • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits <p>Note: To locate a Preferred provider, go to www.fepblue.org and select “Provider Directory” to use our National Doctor & Hospital Finder, or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.</p> <p>Note: See pages 61 and 102 for our coverage of smoking and tobacco cessation treatment.</p> <p>Note: See page 46 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy.</p>	<p>Preferred: \$20 copayment for the visit (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount</p>	<p>Preferred: \$25 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Inpatient professional visits 	<p>Preferred: Nothing (no deductible)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Inpatient hospital or other covered facility	You Pay	
	Standard Option	Basic Option
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Diagnostic tests <p>Note: Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a hospital/treatment facility (excluding a residential treatment center) for rehabilitative treatment of alcoholism or substance abuse.</p> <p>Note: A residential treatment center is not a covered hospital/treatment facility. See Section 10, <i>Definitions</i>, for more information.</p> <p>Note: You must get precertification of inpatient hospital stays; failure to do so will result in a \$500 penalty.</p>	<p>Preferred: \$250 per admission copayment for unlimited days (no deductible)</p> <p>Member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)</p> <p>Non-member: \$350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment</p>	<p>Preferred: \$175 per day copayment up to \$875 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>
Outpatient hospital or other covered facility		
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Individual psychotherapy Group psychotherapy Pharmacologic (medication) management Partial hospitalization Intensive outpatient treatment <p>Note: A residential treatment center is not a covered hospital/treatment facility. See Section 10, <i>Definitions</i>, for more information.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Member: 35% of the Plan allowance (deductible applies)</p> <p>Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: \$25 copayment per day per facility</p> <p>Member/Non-member: You pay all charges</p>
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> Diagnostic tests Psychological testing <p>Note: A residential treatment center is not a covered hospital/treatment facility. See Section 10, <i>Definitions</i>, for more information.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Member: 35% of the Plan allowance (deductible applies)</p> <p>Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.</p>	<p>Preferred: Nothing</p> <p>Member/Non-member: Nothing</p>

Not covered (Inpatient or Outpatient)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> • Marital, family, educational, or other counseling or training services • Services performed by a noncovered provider • Testing and treatment for learning disabilities and mental retardation • Applied behavior analysis (ABA) or ABA therapy • Services performed or billed by residential treatment centers, schools, halfway houses, or members of their staffs <p>Note: We cover professional services as described on pages 94 and 95 when they are provided and billed by a covered professional provider acting within the scope of his or her license.</p> <ul style="list-style-type: none"> • Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present • Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.) • Light boxes • Custodial or long term care (see Definitions) 	All charges	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 101.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS AND SUPPLIES, and prior approval must be renewed periodically.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. Please refer to page 100 for more information about the PSQM program and to Section 3 for more information about prior approval.
- During the course of the year, we may move a brand-name drug from Tier 2 (preferred brand-name) to Tier 3 (non-preferred brand-name) if a generic equivalent becomes available or if new safety concerns arise. We may also move a specialty drug from Tier 4 (preferred) to Tier 5 (non-preferred) if a generic equivalent becomes available or if new safety concerns arise. If your drug is moved to a higher Tier, your cost-share will increase. Tier reassignments during the year are not considered benefit changes.
- **Under Standard Option,**
 - You may use the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program to fill your prescriptions.
 - The calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.
 - PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option,**
 - **You must use Preferred providers or the Specialty Drug Pharmacy Program in order to receive benefits. See page 21 for the exceptions to this requirement.** Our specialty drug pharmacy is a Preferred provider.
 - There is **no calendar year deductible**.
 - The Mail Service Prescription Drug Program is **not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, at a Non-preferred retail pharmacy, through our Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, our Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. See page 148 for the definition of “specialty drugs.”

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, in order to receive benefits. See page 148 for the definition of “specialty drugs.”

Note: Both Preferred and Non-preferred retail pharmacies may offer options for ordering prescription drugs online. Drugs ordered online may be delivered to your home; however, these online orders are not a part of the Mail Service Prescription Drug Program, described on page 107.

Note: Due to manufacturer restrictions, a small number of specialty drugs used to treat rare or uncommon conditions may be available only through a Preferred retail pharmacy. See page 105 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **We use an open formulary.** This includes a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our preferred drug list.

Under Standard Option, we may ask your doctor to substitute a preferred drug in order to help control costs. If you purchase a drug that is not on our preferred drug list, your cost will be higher. We cover drugs that require a prescription (whether or not they are on our preferred drug list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our preferred drug list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our preferred drug list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our preferred drug list.)

Note: Before filling your prescription, please check the preferred/non-preferred status of your medication. Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year.

Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, we work with our Pharmacy and Therapeutics Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in, the Blue Cross and Blue Shield Service Benefit Plan. The Committee meets quarterly to review new and existing drugs to assist us in our assessment of these drugs for safety and efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. The Committee's recommendations, together with our evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

Tier 1: Includes generic drugs

Tier 2: Includes preferred brand-name drugs

Tier 3: Includes non-preferred brand-name drugs

Tier 4: Includes preferred specialty drugs

Tier 5: Includes non-preferred specialty drugs

You can view our formulary which includes the preferred drug list on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). If you do not find your drug on the formulary or the preferred drug list, please call 1-800-624-5060. Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

Generic equivalent drugs have the same active ingredients as their brand-name equivalents. By filling your prescriptions (or those of family members covered by the Plan) at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug. Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.**

- **Why use generic drugs?** Generic drugs are generally lower cost drugs. Generic drugs have the same quality and strength as brand-name drugs and must meet the same strict standards for quality and effectiveness set by the U.S. Food and Drug Administration (FDA), as brand-name drugs.

You can save money by using generic drugs. Keep in mind that doctors often have several medication options to treat their patients. If your brand-name drug does not have an equivalent generic drug, there may be a generic alternative drug available to treat your condition. You may want to talk with your doctor about generic drugs and how you can reduce your prescription drug costs. You or your doctor may request a brand-name drug even if a generic option is available. See Section 10, *Definitions*, for more information about generic alternatives and generic equivalents.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**

Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail or Specialty Drug Pharmacy Program. You may purchase a supply of **more than 21 days up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill Tier 1 (generic), Tier 2 (preferred brand-name), and Tier 3 (non-preferred brand-name) prescriptions for the first time, you may purchase **up to** a 30-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills. See pages 105 and 108 for dispensing limitations when you fill Tier 4 and Tier 5 specialty drug prescriptions.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used.** Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:

- Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.
- Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills.
- Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines.

For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage.** In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. **Prior approval must be renewed periodically.** To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval.

Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.

Covered medications and supplies**Standard Option Generic Incentive Program**

Your cost-share will be waived for the first 4 generic prescriptions filled (and/or refills ordered) per drug per calendar year if you purchase a brand-name drug listed below while a member of the Service Benefit Plan and then change to a corresponding generic drug replacement while still a member of the Plan.

Preferred Retail Pharmacy

- Your 20% coinsurance amount (15% when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 coinsurance waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for your coinsurance amount.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

Mail Service Prescription Drug Program

- Your \$15 copayment (\$10 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 copayment waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for the copayment.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

If you take one of these brand-name drugs . . .	And change to one of these generic drug replacements . . .	<p>You will receive your first 4 prescription fills (or refills) of the corresponding generic drug at no charge.</p> <p>(Please see the Standard Option Generic Incentive Program description above for complete information.)</p>
Actonel, Boniva, Fosamax	alendronate or ibandronate	
Aciphex, Dexilant (formerly Kapidex), Nexium, Prevacid, Prilosec, Protonix, Zegerid	omeprazole, lansoprazole, or pantoprazole	
Ambien CR, Lunesta, Rozerem	zaleplon, zolpidem, or zolpidem extended-release	
Advicor, Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, Simcor, Vytorin, Zocor	simvastatin, pravastatin, lovastatin, atorvastatin, or fluvastatin	
Caduet	simvastatin, pravastatin, lovastatin, atorvastatin, fluvastatin, amlodipine, or amlodipine/atorvastatin	
Famvir	famciclovir	
Valtrex	valacyclovir	
Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, Teveten	losartan, candesartan, irbesartan, or eprosartan	
Atacand HCT, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Teveten HCT	losartan HCTZ, candesartan HCT, irbesartan HCT, or eprosartan HCTZ	
Detrol, Oxytrol, Sanctura, Toviaz, Vesicare	oxybutynin, oxybutynin extended-release, or trospium	
Detrol LA, Enablex, Sanctura XR	oxybutynin extended-release or trospium extended-release	
Betimol, Istalol, Timoptic-XE, Optipranolol	timolol maleate ophthalmic	

Please note the list of eligible generic drug replacements may change if additional generic drugs corresponding to the listed brand-name drugs become available during the year. For the most up-to-date information, please visit our Pharmacy Program Web site through www.fepblue.org.

Covered medications and supplies – continued on next page

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Covered medications and supplies (continued)	Standard Option	Basic Option
<ul style="list-style-type: none">Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase <i>Note:</i> See page 104 for our coverage of medicines to promote better health as recommended under the Affordable Care Act. <i>Note:</i> See Section 5(a), page 58, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.Insulin <i>Note:</i> See page 57 for our coverage of insulin pumps.Diabetic test stripsLancetsNeedles and disposable syringes for the administration of covered medicationsClotting factors and anti-inhibitor complexes for the treatment of hemophiliaDrugs to aid smoking and tobacco cessation that require a prescription by Federal law <i>Note:</i> We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 109. <i>Note:</i> You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 109 for more information.Contraceptive drugs and devices, limited to:<ul style="list-style-type: none">Diaphragms and contraceptive ringsInjectable contraceptivesIntrauterine devices (IUDs)Implantable contraceptivesOral and transdermal contraceptives<i>Note:</i> We waive your cost-share for generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, when you purchase them at a Preferred retail pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. See pages 105 and 107 for details.Drugs for the diagnosis and treatment of infertility, except as described on page 111	See page 101 and pages 103-110	See page 101 and pages 103-110

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<ul style="list-style-type: none"> Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to: <ul style="list-style-type: none"> Emergency contraceptive pills Female condoms Spermicides Sponges <p>Note: We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet FDA standards for OTC products. To receive benefits, you must use a Preferred retail pharmacy and present the pharmacist with a written prescription from your physician.</p>	<p>Preferred retail pharmacy: Nothing (no deductible)</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>
<p>Routine immunizations when provided by a Preferred retail pharmacy that participates in our vaccine network (see below) and administered in compliance with applicable state law and pharmacy certification requirements, limited to:</p> <ul style="list-style-type: none"> Herpes Zoster (shingles) vaccines Human Papillomavirus (HPV) vaccines Influenza (flu) vaccines Pneumococcal vaccines Meningococcal vaccines <p>Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more of the routine immunizations listed above. Check with your pharmacy or call our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) to see which vaccines your pharmacy can provide.</p>	<p>Preferred retail pharmacy: Nothing (no deductible)</p> <p>Non-preferred retail pharmacy: You pay all charges (except as noted below)</p> <p>Note: You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges (except as noted below)</p> <p>Note: You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”), limited to:</p> <ul style="list-style-type: none"> • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women capable of pregnancy • Vitamin D supplements for adults, age 65 and over, limited to a recommended daily allowance of 600-800 international units (I.U.s) per day • Aspirin for men age 45 through 79 and women age 55 through 79 <p>Note: Benefits are not available for <i>Tylenol</i>, <i>Ibuprofen</i>, <i>Aleve</i>, etc.</p> <p>Note: Benefits for the medicines listed above are subject to the dispensing limitations described on page 100 and are limited to recommended prescribed limits.</p> <p>Note: To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist.</p> <p>Note: For a complete list of preventive services recommended under the Affordable Care Act, visit: http://www.healthcare.gov/prevention/index.html. See pages 41-45 in Section 5(a) for information about other covered preventive care services.</p> <p>Note: See page 109 for our coverage of smoking and tobacco cessation medicines.</p>	<p>Preferred retail pharmacy: Nothing (no deductible)</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (<i>continued</i>)	You Pay	
	Standard Option	Basic Option
<p>Here is how to obtain your prescription drugs and supplies:</p> <p>Preferred Retail Pharmacies</p> <ul style="list-style-type: none"> • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit the Web site of your Preferred retail pharmacy to request your prescriptions • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org <p>Note: Retail pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies.</p> <p>Note: Benefits for Tier 4 and Tier 5 specialty drugs purchased at a Preferred retail pharmacy are limited to one purchase of up to a 30-day supply for each prescription dispensed. All refills must be obtained through the Specialty Drug Pharmacy Program. See page 108 for more information.</p> <p>Note: For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for drugs obtained from a retail pharmacy, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For benefit information about prescription drugs supplied by Non-preferred retail pharmacies, please refer to page 106.</p> <p>Note: For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077).</p> <p>Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.</p> <p>Note: We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative.</p>	<p>Tier 1 (generic drug): 20% of the Plan allowance (no deductible)</p> <p>Note: You pay 15% of the Plan allowance when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 101 for complete information.</p> <p>Tier 2 (preferred brand-name drug): 30% of the Plan allowance (no deductible)</p> <p>Tier 3 (non-preferred brand-name drug): 45% of the Plan allowance (no deductible)</p> <p>Tier 4 (preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply</p> <p>Tier 5 (non-preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply</p> <p>Note: If there is no generic drug available, you must still pay the brand-name coinsurance amount when you receive a brand-name drug.</p> <p>Note: We may move a Tier 2 brand-name drug to Tier 3 or a Tier 4 specialty drug to Tier 5 during the course of the year. See page 98 for more information.</p>	<p>Tier 1 (generic drug): \$10 copayment for each purchase of up to a 30-day supply (\$30 copayment for 90-day supply)</p> <p>Tier 2 (preferred brand-name drug): \$45 copayment for each purchase of up to a 30-day supply (\$135 copayment for 90-day supply)</p> <p>Tier 3 (non-preferred brand-name drug): 50% of Plan allowance (\$55 minimum) for each purchase of up to a 30-day supply, (\$165 minimum for 90-day supply)</p> <p>Tier 4 (preferred specialty drug): \$60 for up to a 30-day supply only</p> <p>Tier 5 (non-preferred specialty drug): \$80 for up to a 30-day supply only</p> <p>Note: If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: We may move a Tier 2 brand-name drug to Tier 3 or a Tier 4 specialty drug to Tier 5 during the course of the year. See page 98 for more information.</p> <p>Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
Non-preferred Retail Pharmacies	<p>45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount (no deductible)</p> <p>Note: If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>	<i>All charges</i>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Mail Service Prescription Drug Program</p> <p>Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills.</p> <p>Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program.</p> <p>Note: Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program. Please refer to page 108 for information about the Specialty Drug Pharmacy Program.</p> <p>Note: We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative.</p> <p>Contact Us: If you have any questions about this program, or need assistance with your Mail Service drug orders, please call 1-800-262-7890 (TDD: 1-800-216-5343).</p>	<p>Mail Service Program:</p> <p>Tier 1 (generic drug): \$15 copayment (no deductible)</p> <p>Note: You pay a \$10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary.</p> <p>Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 101 for complete information.</p> <p>Tier 2 (preferred brand-name drug): \$80 copayment (no deductible)</p> <p>Tier 3 (non-preferred brand-name drug): \$105 copayment (no deductible)</p> <p>Note: The copayment amounts listed above for brand-name drugs only apply to your first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; you pay a \$50 copayment per brand-name prescription/refill thereafter.</p> <p>Note: If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.</p> <p>Note: We may move a Tier 2 brand-name drug to Tier 3 during the course of the year. See page 98 for more information.</p>	<p>No benefit</p> <p>Note: Although you do not have access to the Mail Service Prescription Drug Program, you may request home delivery of prescription drugs you purchase from Preferred retail pharmacies offering options for online ordering. See page 105 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.</p> <p>Note: See page 108 for information about the Specialty Drug Pharmacy Program.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Specialty Drug Pharmacy Program</p> <p>We cover specialty drugs that are listed on the Service Benefit Plan Specialty Drug List. (See page 148 for the definition of “specialty drugs.”)</p> <p>If your doctor orders more than a 21-day supply of covered specialty drugs, you can use this service. A Specialty Drug pharmacy representative will speak with you to schedule delivery and ask you about any side effects each time you order a new prescription or a refill.</p> <p>Note: Benefits for the first three fills of each Tier 4 or Tier 5 specialty drug are limited to a 30-day supply. Benefits are available for a 90-day supply after the third fill.</p> <p>The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that is most convenient for you. Please refer to Section 7 for instructions on using the program.</p> <p>Note: If your specialty drug order is for 21 days or less, please call the Specialty Drug Pharmacy Program number listed below for assistance.</p> <p>Note: The list of covered specialty drugs is subject to change. For the most up-to-date listing, call the number listed below or visit our Web site, www.fepblue.org.</p> <p>Note: Due to manufacturer restrictions, a small number of specialty drugs may only be available through a Preferred retail pharmacy. You will be responsible for paying only the copayments shown here for specialty drugs affected by these restrictions.</p> <p>Contact Us: If you have any questions about this program, or need assistance with your specialty drug orders, please call 1-888-346-3731 (TDD: 1-877-853-9549).</p>	<p>Specialty Drug Pharmacy Program:</p> <p>Tier 4 (preferred specialty drug): \$35 copayment for up to a 30-day supply (\$95 copayment for up to a 90-day supply) (no deductible)</p> <p>Tier 5 (non-preferred specialty drug): \$55 copayment for up to a 30-day supply (\$155 copayment for up to a 90-day supply) (no deductible)</p> <p>Note: The copayments listed above for 90-day supplies of specialty drugs apply to the first 30 prescriptions refilled or ordered per calendar year; thereafter, your copayment is \$50 for each 90-day supply.</p>	<p>Specialty Drug Pharmacy Program:</p> <p>Tier 4 (preferred specialty drug): \$50 copayment for up to a 30-day supply (\$140 copayment for 90-day supply)</p> <p>Tier 5 (non-preferred specialty drug): \$70 copayment for up to a 30-day supply (\$195 copayment for 90-day supply)</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Smoking and Tobacco Cessation Medications</p> <p>If you are age 18 or over, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred retail pharmacy.</p> <p>To qualify, complete the Blue Health Assessment (BHA) questionnaire indicating you are a tobacco user, and create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see pages 118 and 119.</p> <p>The following medications are covered through this program:</p> <ul style="list-style-type: none"> • Generic medications available by prescription: <ul style="list-style-type: none"> – Bupropion ER 150 mg tablet – Bupropion SR 150 mg tablet • Brand-name medications available by prescription: <ul style="list-style-type: none"> – Chantix 0.5 mg tablet – Chantix 1 mg cont monthly pack – Chantix 1 mg tablet – Chantix starting monthly pack – Nicotrol cartridge inhaler – Nicotrol NS Spray 10 mg/ml • Over-the-counter (OTC) medications <p>Note: To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred retail pharmacy.</p> <p>Note: These benefits apply only when all of the criteria listed above are met. Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above.</p> <p>Note: See page 61 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.</p>	<p>Preferred retail pharmacy: Nothing (no deductible)</p> <p>Non-preferred retail pharmacy: You pay all charges</p>	<p>Preferred retail pharmacy: Nothing</p> <p>Non-preferred retail pharmacy: You pay all charges</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p>Drugs from other sources</p> <ul style="list-style-type: none"> Covered prescription drugs and supplies not obtained at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program <p>Note: We cover drugs and supplies purchased overseas as shown here, as long as they are the equivalent to drugs and supplies that by Federal law of the United States require a prescription. Please refer to pages 121 and 122 in Section 5(i) for more information.</p> <p>Note: For covered prescription drugs and supplies purchased outside of the United States, Puerto Rico, and the U.S. Virgin Islands, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services.</p> <ul style="list-style-type: none"> Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: <ul style="list-style-type: none"> Physician's office – Section 5(a) Hospital (inpatient or outpatient) – Section 5(c) Hospice agency – Section 5(c) Please refer to page 105 for prescription drugs obtained from a Preferred retail pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility 	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating/Member: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating/Non-member: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Member or Non-participating/Non-member: You pay all charges</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay	
	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Medical supplies such as dressings and antiseptics • Drugs and supplies for cosmetic purposes • Drugs and supplies for weight loss • Drugs for orthodontic care, dental implants, and periodontal disease • Drugs used in conjunction with assisted reproductive technology (ART) and assisted insemination procedures • Insulin and diabetic supplies except when obtained from a retail pharmacy or through the Mail Service Prescription Drug Program (under Standard Option only), or except when Medicare Part B is primary • Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your state law <p>Note: See page 104 for our coverage of medicines recommended under the Affordable Care Act and page 109 for smoking and tobacco cessation medications.</p> <p>Note: See Section 5(a), page 58 for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.</p> <ul style="list-style-type: none"> • Drugs for which prior approval has been denied or not obtained • Infant formula other than described on page 58 • Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy • Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States • Over-the-counter (OTC) contraceptive drugs and devices, except as described on page 103 • Drugs used to terminate pregnancy 	All charges	All charges

Section 5(g). Dental benefits**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*, for additional information.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **Note:** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.
- **Under Standard Option,**
 - The calendar year deductible of \$350 per person (\$700 per family) applies only to the accidental injury benefit below.
- **Under Basic Option,**
 - There is **no calendar year deductible**.
 - **You must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**

Accidental injury benefit	You Pay	
	Standard Option	Basic Option
<p>We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.</p> <p>Note: An accidental injury is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries.</p> <p>Note: A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.</p>	<p>Preferred: 15% of the Plan allowance (deductible applies)</p> <p>Participating: 35% of the Plan allowance (deductible applies)</p> <p>Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.</p>	<p>\$25 copayment per visit</p> <p>Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers. See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>

Dental benefits – continued on next page

Dental benefits**What is Covered**

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 117.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits		Standard Option Only	
Covered service	We pay		You pay
Clinical oral evaluations	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluation (<i>up to 2 per person per calendar year</i>)	\$12	\$8	
Limited oral evaluation	\$14	\$9	
Comprehensive oral evaluation	\$14	\$9	
Detailed and extensive oral evaluation	\$14	\$9	

Dental benefits – continued on next page

Standard Option dental benefits <i>(continued)</i>	Standard Option Only		
Covered service	We pay		You pay
Diagnostic imaging	<u>To age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left <i>Note:</i> For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral complete series	\$36	\$22	
Intraoral periapical first image	\$7	\$5	
Intraoral periapical each additional image	\$4	\$3	
Intraoral occlusal image	\$12	\$7	
Extraoral first image	\$16	\$10	
Extraoral each additional image	\$6	\$4	
Bitewing – single image	\$9	\$6	
Bitewings – two images	\$14	\$9	
Bitewings – four images	\$19	\$12	
Vertical bitewings	\$12	\$7	
Posterior-anterior or lateral skull and facial bone survey image	\$45	\$28	
Panoramic image	\$36	\$23	
Tests and laboratory exams			
Pulp vitality tests	\$11	\$7	
Palliative treatment			
Palliative (emergency) treatment of dental pain – minor procedure	\$24	\$15	
Protective restoration	\$24	\$15	
Preventive			
Prophylaxis – adult <i>(up to 2 per person per calendar year)</i>	---	\$16	
Prophylaxis – child <i>(up to 2 per person per calendar year)</i>	\$22	\$14	
Topical application of fluoride or fluoride varnish	\$13	\$8	
Space maintenance (passive appliances)			
Space maintainer – fixed – unilateral	\$94	\$59	
Space maintainer – fixed – bilateral	\$139	\$87	
Space maintainer – removable – unilateral	\$94	\$59	
Space maintainer – removable – bilateral	\$139	\$87	
Recementation of space maintainer	\$22	\$14	

Dental benefits – continued on next page

Standard Option dental benefits <i>(continued)</i>		Standard Option Only	
Covered service	We pay		You pay
Amalgam restorations (including polishing)	<u>To Age 13</u>	<u>Age 13 and over</u>	<p>All charges in excess of the scheduled amounts listed to the left</p> <p>Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).</p>
Amalgam – one surface, primary or permanent	\$25	\$16	
Amalgam – two surfaces, primary or permanent	\$37	\$23	
Amalgam – three surfaces, primary or permanent	\$50	\$31	
Amalgam – four or more surfaces, primary or permanent	\$56	\$35	
Resin-based composite restorations			
Resin-based composite – one surface, anterior	\$25	\$16	
Resin-based composite – two surfaces, anterior	\$37	\$23	
Resin-based composite – three surfaces, anterior	\$50	\$31	
Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$56	\$35	
Resin-based composite – one surface, posterior	\$25	\$16	
Resin-based composite – two surfaces, posterior	\$37	\$23	
Resin-based composite – three surfaces, posterior	\$50	\$31	
Resin-based composite – four or more surfaces, posterior	\$50	\$31	
Inlay restorations			
Inlay – metallic – one surface	\$25	\$16	
Inlay – metallic – two surfaces	\$37	\$23	
Inlay – metallic – three or more surfaces	\$50	\$31	
Inlay – porcelain/ceramic – one surface	\$25	\$16	
Inlay – porcelain/ceramic – two surfaces	\$37	\$23	
Inlay – porcelain/ceramic – three or more surfaces	\$50	\$31	
Inlay – resin-based composite – one surface	\$25	\$16	
Inlay – resin-based composite – two surfaces	\$37	\$23	
Inlay – resin-based composite – three or more surfaces	\$50	\$31	
Other restorative services			
Pin retention – per tooth, in addition to restoration	\$13	\$8	

Dental benefits – continued on next page

Standard Option dental benefits <i>(continued)</i>		Standard Option Only	
Covered service	We pay		You pay
Extractions – includes local anesthesia and routine post-operative care	<u>To Age 13</u>	<u>Age 13 and over</u>	All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Extraction, erupted tooth or exposed root	\$30	\$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$43	\$27	
Surgical removal of residual tooth roots (cutting procedure)	\$71	\$45	
General anesthesia in connection with covered extractions	\$43	\$27	
<i>Not covered: Any service not specifically listed above</i>	<i>Nothing</i>	<i>Nothing</i>	<i>All charges</i>

Dental benefits – continued on next page

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a \$25 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, go to www.fepblue.org and select “Provider Directory” to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits		Basic Option Only	
Covered service		We pay	You pay
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year		Preferred: All charges in excess of your \$25 copayment	Preferred: \$25 copayment per evaluation
		Participating/Non-participating:	Participating/Non-participating:
		Nothing	You pay all charges
Diagnostic imaging Intraoral – complete series including bitewings (<i>limited to 1 complete series every 3 years</i>) Bitewing – single image* Bitewings – two images* Bitewings – four images* *Benefits are limited to a combined total of 4 images per person per calendar year			
Preventive Prophylaxis – adult (<i>up to 2 per calendar year</i>) Prophylaxis – child (<i>up to 2 per calendar year</i>) Topical application of fluoride or fluoride varnish – for children only (<i>up to 2 per calendar year</i>) Sealant – per tooth, first and second molars only (<i>once per tooth for children up to age 16 only</i>)			
<i>Not covered: Any service not specifically listed above</i>		<i>Nothing</i>	<i>All charges</i>

Section 5(h). Special features

Special feature	Description
Health Tools	<p>Stay connected to your health and get the answers you need when you need them by using Health Tools 24 hours a day, 365 days a year. Go to www.fepblue.org or call 1-888-258-3432 toll-free to check out these valuable easy-to-use services:</p> <ul style="list-style-type: none"> • Talk directly with a Registered Nurse any time of the day or night via telephone, secure email, or live chat. Ask questions, get medical advice, or get help determining when to go to see a doctor. Please keep in mind that benefits for any health care services you may seek after using Health Tools are subject to the terms of your coverage under this Plan. • Personal Health Record – Access your secure online personal health record for information such as the medications you’re taking, recent test results, and medical appointments. Update, store, and track health-related information at any time. • Blue Health Assessment – Complete this online health and lifestyle questionnaire and receive additional assistance with your health care expenses. See page 119 for complete information. • Tobacco Cessation Incentive Program – If you are age 18 or over and would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. Start by completing the Blue Health Assessment (BHA) questionnaire indicating you are a tobacco user, and create a Tobacco Cessation Quit Plan using our Online Health Coach. You will then be eligible to receive certain smoking and tobacco cessation medications at no charge. Both prescription and over-the-counter (OTC) tobacco cessation products obtained from a Preferred retail pharmacy are included in this program. See page 109 for more information. • My Multimedia Health Library offers an extensive variety of educational tools using videos, recorded messages, and colorful online material that provide up-to-date information about a wide range of health-related topics. • Benefits Statements – Access quarterly and annual statements of recent medical and pharmacy claims and out-of-pocket costs for each family member.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org , adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Adjust the text size by clicking on the plus (“+”) or minus (“–”) boxes that appear at the top right of every page.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands.
Healthy Families	Our Healthy Families suite of resources is for families with children and teens, ages 2-19. Healthy Families provides activities and tools to help parents teach their children about weight management, nutrition, physical activity, and personal wellbeing. For more information, go to www.fepblue.org .
WalkingWorks® Wellness Program	<i>WalkingWorks®</i> can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online <i>WalkingWorks</i> tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. <i>WalkingWorks</i> was developed in cooperation with the President’s Council on Physical Fitness and Sports.

Special features – continued on next page

Blue Health Assessment	<p>The Blue Health Assessment (BHA) questionnaire is an easy and engaging online health evaluation program which can be completed in 10-15 minutes. Your BHA answers are evaluated to create a unique health action plan. Based on the results of your BHA, you can select personalized goals, receive supportive advice, and easily track your progress through our Online Health Coach.</p> <p>When you complete your BHA, you are entitled to receive a \$40 health account to be used for most qualified medical expenses. For those with Self and Family coverage, up to two (2) adult members, age 18 or over, are eligible for the \$40 health account. We will send each eligible member a debit card to access his or her account. Please keep your card for future use even if you use all of your health account dollars; you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited.</p> <p>In addition to the \$40 health account, you are entitled to receive a maximum of \$35 in additional credits to your health account for achieving up to three personalized lifestyle management goals. After completing the BHA, you may access the Online Health Coach to set personalized goals designed to improve your health through increased exercise, healthier nutrition habits, managing your weight, reduced stress, and/or better emotional health. We will add \$15 to your health account when you achieve your first goal, \$10 when you achieve your second goal, and another \$10 when you achieve your third goal. By completing the BHA and a maximum of three lifestyle management goals, you can earn up to a total of \$75 in health account dollars. You must complete the BHA and your selected goals during the calendar year in order to receive these incentives.</p> <p>The Online Health Coach also features goals that focus on management of specific medical conditions and we encourage members to take full advantage of these valuable resources. However, health account dollars are available only when you complete goals related to exercise, nutrition, weight management, stress, and emotional health, and are limited to a maximum of three completed goals per calendar year.</p> <p>Note: In order to receive your incentives, you must complete all eligible activities no later than December 21, 2014, to allow for end-of-year processing. Please allow ample time to complete all activities by this date.</p> <p>Visit our Web site, www.fepblue.org, for more information and to complete the BHA so you can receive your individualized results and begin working toward achieving your goals. You may also request a printed BHA by calling 1-888-258-3432 toll-free.</p>
Diabetes Management Incentive Program	<p>The Diabetes Management Incentive Program is designed to provide critical health education to people with diabetes, to help assist people with diabetes in improving their blood sugar control, and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of \$75 toward a health account to be used for most qualified medical expenses. To qualify for the Diabetes Management Incentive Program, you must be age 18 or over and complete the Blue Health Assessment (BHA) questionnaire indicating you have diabetes. The BHA is available on our Web site, www.fepblue.org. For those with Self and Family coverage, this incentive program is limited to two (2) adult members.</p> <p>The following activities are rewarded through this program:</p> <ul style="list-style-type: none"> • \$10 for having your A1c test performed by a covered provider (maximum of 2 per year) • \$5 for reporting A1c levels to the Diabetes Management Incentive Program via our Web site, www.fepblue.org (maximum of 2 per year) • \$10 for receiving diabetic glucose test strips through our pharmacy program (maximum of 4 per year) • \$10 for receiving a diabetic foot exam from a covered provider (maximum of 1 per year) <p>You can also receive a maximum of 1 of the following 3 rewards:</p> <ul style="list-style-type: none"> • \$20 for enrolling in a diabetes disease management program (maximum of 1 per year) • \$20 for receiving a diabetic education visit from a covered provider (maximum of 1 per year) • \$5 for completing a web-based diabetes education quiz on our Web site, www.fepblue.org (maximum of 4 per year) <p>Note: Once you earn the maximum of \$75 through this program for the calendar year, additional eligible activities are encouraged but will not be rewarded.</p> <p>Note: For more information about this program, including eligibility and enrollment information, please visit www.fepblue.org or call the number on the back of your Service Benefit Plan ID card.</p>

Special features – continued on next page

MyBlue® Customer eService	<p>Visit MyBlue® Customer eService at www.fepblue.org to check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and track how you use your benefits. Additional features include:</p> <ul style="list-style-type: none"> • Online EOBs – You can view, download, and print your explanation of benefits (EOB) forms. Simply log onto MyBlue® Customer eService via www.fepblue.org and click on the “Medical & Pharmacy Claims” link. From there you can enter the desired date range and select the “EOB” link next to each claim to access your EOB. • Opt Out of Paper EOBs – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs. You can opt out of receiving paper EOBs and access your EOBs exclusively online. From the main menu, select the “EOB Mailing Preference” link and follow the on-screen instructions. • Personalized Messages – Our EOBs provide a wide range of messages just for you and your family, ranging from preventive care opportunities to enhancements to our online services!
National Doctor & Hospital FinderSM	<p>To find nationwide listings of Preferred providers, go to www.fepblue.org and select “Provider Directory” to use our National Doctor & Hospital Finder.</p>
Care Management Programs	<p>If you have a chronic disease or complex health care needs, the Service Benefit Plan offers members two types of Care Management Programs that provide patient education and clinical support.</p> <ul style="list-style-type: none"> • Case Management: We provide members with complex health care needs with the services of a professional case manager to assess the needs of the member and when appropriate, coordinate, evaluate, and monitor the member's care. • Disease Management: We provide programs to help members adopt effective self-care habits to improve their self-management of diabetes; asthma; chronic obstructive pulmonary disease (COPD); coronary artery disease; congestive heart failure; and certain rare conditions. You may receive information from us regarding the programs available to you in your area. <p>If you have any questions regarding these programs, please contact us at the customer service number on the back of your ID card.</p>
Flexible benefits option	<p>Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a flexible benefits option. This option allows professional case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an alternative benefits agreement that includes the terms listed below, in addition to any other terms specified in the agreement.</p> <ul style="list-style-type: none"> • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the alternative benefits agreement, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. <p>If you sign the alternative benefits agreement, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us or circumstances change. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written alternative benefits agreement must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.</p> <p>Note: If we deny a request for precertification or prior approval of regular contract benefits, or if we deny regular contract benefits for services you have already received, you may dispute our denial of regular contract benefits under the OPM disputed claims process (see Section 8).</p>

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States, Puerto Rico, and the U.S. Virgin Islands, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 122 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule or a provider-negotiated discount as our Plan allowance. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States, Puerto Rico, and the U.S. Virgin Islands.**

Under both Standard and Basic Options, when the Plan allowance is based on the Overseas Fee Schedule, you pay any difference between our payment and the amount billed, in addition to any applicable coinsurance and/or copayment amounts. You must also pay any charges for noncovered services (and, under Standard Option only, any applicable deductible amount). **Under both Standard and Basic Options**, when the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts and, under Standard Option only, any applicable deductible amount. You must also pay any charges for noncovered services.

For **facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 81-84.

For **prescription drugs purchased at overseas pharmacies**, we provide benefits at Preferred benefit levels, using the billed charge as our Plan allowance. Under both Standard and Basic Options, members pay the applicable coinsurance. Standard Option members are not required to meet the calendar year deductible when they purchase drugs at pharmacies located overseas. See page 110 in Section 5(f) for more information.

For **dental care** you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option**, you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option**, you must pay the \$25 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. We also have a network of professional providers who have agreed to accept a negotiated amount as payment in full for their services. The Worldwide Assistance Center can help you locate a hospital or physician in our network near where you are staying. You may also view a list of our network providers on our Web site, www.fepblue.org. You will have to file a claim to us for reimbursement for professional services unless you or your provider contacts the Worldwide Assistance Center in advance to arrange direct billing and payment to the provider.

If you are overseas and need assistance locating providers (whether in or out of our network), contact the Worldwide Assistance Center (provided by AXA Assistance), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 1-800-699-4337 or email the Worldwide Assistance Center at fepoverseas@axa-assistance.us. AXA Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States, Puerto Rico, and the U.S. Virgin Islands, send a completed Overseas Claim Form and itemized bills to: Federal Employee Program, Overseas Claims, P.O. Box 261570, Miami, FL 33126. You may also fax your claims to us at 001-410-781-7637 (or 1-888-650-6525 toll-free). We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to: Mailroom Administrator, FEP® Overseas Claims, P.O. Box 14112, Lexington, KY 40512-4112. You may also email inquiries to us through our Web site (www.fepblue.org) via MyBlue® Customer eService, or call us at 1-888-999-9862, using the appropriate AT&T country codes available at www.fepblue.org under Contact Us. You may obtain Overseas Claim Forms from our Web site, or request them through fepoverseas@axa-assistance.us or your Local Plan.

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States, Puerto Rico, and the U.S. Virgin Islands, send a completed FEP® Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057, or fax your claim to: 001-480-614-7674. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

While overseas, you may be able to order your prescription drugs through the Mail Service Prescription Drug Program (under Standard Option only) or our Specialty Drug Pharmacy Program as long as:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories),
- The prescribing physician is licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, and
- Delivery of the prescription is permitted by law and is in accordance with the manufacturer's guidelines.

See Section 5(f) for more information about Preferred retail pharmacies with online ordering options, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Note: In most cases, temperature-sensitive drugs cannot be sent to APO/FPO addresses due to the special handling they require.

Note: For overseas countries with laws restricting the importation of prescription drugs from any other country, we are unable to ship drugs from our Mail Service Prescription Drug Program to Standard Option members living overseas, or from our Specialty Drug Pharmacy Program to Standard or Basic Option members living overseas, even when a valid APO or FPO address is available. You may continue to obtain your prescription drugs from a local overseas pharmacy and submit a claim to us for reimbursement by faxing it to 001-480-614-7674 or filing it via our Web site at www.fepblue.org/myblue.

Non-FEHB benefits available to Plan members

The benefits on these pages are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Blue365[®]

Blue365[®] is a discount program available to all Service Benefit Plan members that provides valuable resources for healthier living such as:

- Discounts on laser vision correction
- Discounts on hearing aids
- Discounts on diet and weight management programs

With Blue365, there is no paperwork to fill out. All you have to do is visit the designated Web sites to save. Please visit www.fepblue.org and click on “Blue365.” Select *Get Started Now!* and then login to MyBlue[®] with your Username and Password to learn more about the various Blue365 vendors and discounts.

The Blue Cross and Blue Shield Service Benefit Plan may receive payments from Blue365 vendors. The Plan does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Health Club Memberships

You have access to a network of over 8,000 fitness facilities nationwide through Healthways Fitness Your Way. You pay a \$25 initiation fee and a \$25 monthly fee per person, by credit card, directly to Healthways. As a member, you're entitled to unlimited visits to network facilities and all amenities included in a general membership.* You are not limited to a specific facility; you can choose to use any facility that participates in the network. There is a three-month commitment. If you stop participating for three months or more, you will need to pay an additional \$25 initiation fee. You also have access to online tools, trackers, and the Daily Challenge. For more information or to enroll, go to www.fepblue.org.

*Taxes may apply. Individuals must be 18 or older to purchase a membership.

Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual/erectile dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, Staxyn tablet, Viagra tablet, and Yohimbine;

For weight loss: Adipex-P, Belviq, Benzphetamine, Bontril PDM, Didrex, Diethylpropion, Meridia capsule, Phendimetrazine, Phentermine, Pro-Fast SR, Qsymia, Suprenza ODT, and Xenical capsule;

For hair removal: Vaniqa cream; *For hair growth:* Propecia;

For skin pigmenting/depigmenting/re-pigmenting: Retinoids [Renova 0.02% (tretinoin) and Avage 0.1% (tazarotene)], Hydroquinone-containing products (Aclaro, Eldoquin Forte, Epiquin Micro, Lustra, Melanex, Melpaque, Nuquin, Obagi Products, Remergent, Solaquin Forte, and Tri-Luma), Monobenzone products (Benoquin), and Tretinoin 0.02%; and

For Miscellaneous: Peridex and Latisse.

Drugs may be added to this list as they are approved by the U.S. Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Vision Care Affinity Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 41,000 service locations including optometrists, ophthalmologists, and many retailers. For a complete description of the program or to find a provider near you, go to www.fepblue.org and click on “Benefit Plans.” You may also call us at 1-800-551-3337 between 8:00 a.m. and 11:00 p.m. Eastern Time, Monday to Friday; 9:00 a.m. to 4:00 p.m. on Saturday; or noon to 4:00 p.m. on Sunday. Please be sure to verify that the provider participates in our Vision Care Affinity Program and ask about the discounts available before your visit, as discounts may vary.

Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the provider's usual fee, or 5% off sales pricing, on laser vision correction procedures. Call 1-800-551-3337 for the nearest location and authorization for the discount.

QualSight® LASIK

QualSight® LASIK offers a nationwide network of credentialed ophthalmologists at over 700 locations in order to provide easy and convenient access for members. Your savings represent 40% to 50% off the overall national average price of traditional LASIK. Significant savings are also provided on newer technologies such as Custom LASIK and bladeless IntraLase. Call 1-877-358-9327 for your free consultation and to see if you are a candidate for one of these procedures.

QualSight LASIK Pricing per Procedure (per eye)*

Traditional LASIK ^{1,2}	\$ 895
Traditional LASIK ^{1,2} and Lifetime Assurance Plan	\$1,295
Traditional LASIK with IntraLase ²	\$1,345
Traditional LASIK with IntraLase ² and Lifetime Assurance Plan	\$1,695
Custom Refractive LASIK ^{1,2}	\$1,320
Custom LASIK ^{1,2} with Lifetime Assurance Plan	\$1,595
Custom LASIK with IntraLase ²	\$1,770
Custom LASIK with IntraLase ² and Lifetime Assurance Plan	\$1,995

¹Pricing includes all FDA-approved procedures (with no additional charges for astigmatism or higher amounts of correction) and surface ablation procedures (PRK, LASEK, Epi-LASIK) as necessary, and as offered at individual network practices. Pricing does not include any required prescription or over-the-counter drugs.

²When offered by participating network providers. *A small percentage of providers may charge more for certain procedures, resulting in a higher fee for the procedure. You will be notified of any additional amount prior to scheduling your pre-operative examination with these providers.*

*Provider participation may vary.

ARAG® Legal Center

Members have access to **The Education Center™** which offers a collection of legal tools and resources that provide helpful tips and simple explanations for complex legal terms and scenarios, as well as guidance on where to turn for more information and assistance. The center includes a secure Personal Information Organizer, Guidebooks and videos, the Law Guide, and an e-newsletter. To access this free service, visit www.fepblue.org, Benefits + Services, select the ARAG Legal Center link, and enter access code 17823fep or contact the ARAG Customer Care Center at 1-800-255-9509. Please reference FEP or 17823 when contacting the ARAG Customer Care Center.

DIY Docs™

Members also have the opportunity to purchase a **DIY Docs** package for a low annual subscription rate of \$69.95 (30% off the \$99 retail rate). DIY Docs members receive access to more than 300 legally-valid documents. These documents are authored and reviewed by attorneys for accuracy and to ensure they are legally valid in all 50 states. Available DIY Docs include a Will, Living Will, Powers of Attorney, Medical Authorization for a Minor, Bill of Sale, Contract, Residential Lease, and much more.

The DIY Docs package includes an easy-to-use document assembly tool that enables members to create, update, store, and print documents at any time. For more information or to purchase DIY Docs, visit www.fepblue.org, Benefits + Services, select the ARAG Legal Center link, and enter access code 17823fep or contact the ARAG Customer Care Center at 1-800-255-9509. Please reference FEP or 17823 when contacting the ARAG Customer Care Center.

TruHearing® MemberPlus® Hearing Aid Program

TruHearing® MemberPlus® offers low, guaranteed pricing on hearing aids through a nation-wide network of more than 3,100 providers. Over 90 state-of-the-art products are available from five of the world's leading manufacturers. The average savings is \$1,780 per pair when compared to national retail prices. Service Benefit Plan members can choose from dozens of top digital hearing aids and pay \$0 out-of-pocket per pair by using the TruHearing MemberPlus Program together with their regular hearing aid coverage (see page 56 of this brochure for benefit details). The MemberPlus enrollment fee is waived for Service Benefit Plan members through December 31, 2014 (a \$108 value). TruHearing gives customers a 45-day money-back guarantee and a 3-year manufacturer warranty on all hearing aid purchases. Call 1-877-360-2436 to schedule an appointment or visit www.fepblue.org for additional information. All appointments must be scheduled through TruHearing.

Note: TruHearing will submit your claim to the Service Benefit Plan. You are responsible for any balances.

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 (*You need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events (see definition on page 144).
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 139), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 140), or state premium taxes however applied.
- Services or supplies ordered, performed, or furnished by you or your immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech, and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures for the treatment of morbid obesity (see pages 63 and 64); and those nutritional counseling services specifically listed on pages 37, 42, 45, and 79.
- Services you receive from a provider that are outside the scope of the provider's licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*.
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.
- Services of standby physicians.
- Self-care or self-help training.
- Custodial or long term care (see *Definitions*).
- Personal comfort items such as beauty and barber services, radio, television, or telephone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under Preventive care, adult and child in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 41-45 and page 84; and certain routine services associated with covered clinical trials (see page 134).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) or ABA therapy.
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for after-hours care, except when associated with services provided in a physician's office.
- Incontinence products such as incontinence garments (including adult or infant diapers, briefs, and underwear), incontinence pads/liners, bed pads, or disposable washcloths.
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring precertification or prior approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment, home nursing care, or physical, occupational, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for dental care to repair accidental injury to sound natural teeth should include documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through the Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See pages 128-129 for information on how to obtain benefits from the Retail Pharmacy Program, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.)

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Prescription drug claims

Preferred Retail Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred retail pharmacies with online ordering options that include home delivery, go to our Web site, www.fepblue.org, visit the “Pharmacy” page, and click on the “Retail Pharmacy” link for your enrollment option (Standard or Basic) to fill your prescriptions. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 24).

See the following paragraph for claim filing instructions.

Non-Preferred Retail Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

- (1) Complete the initial mail order form;
- (2) Enclose your prescription and copayment;
- (3) Mail your order to CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590; and
- (4) Allow up to two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow up to ten (10) days for delivery on refills.

Note: Specialty drugs will not be dispensed through the Mail Service Prescription Drug Program. See page 129 for information about the Specialty Drug Pharmacy Program.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Specialty Drug Pharmacy Program

Standard and Basic Options: If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that is most convenient for you. To order refills, call the same number to arrange your delivery. You may either charge your copayment to your credit card or have it billed to you later.

Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our Web site, www.fepblue.org.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a five-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 121 and 122 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo, and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your explanation of benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the procedure or treatment code and its corresponding meaning.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process **if you disagree with our decision on your post-service claim** (a claim where services, drugs, or supplies have already been provided). In Section 3, ***If you disagree with our pre-service claim decision***, we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may be able to appeal directly to the U.S. Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please visit www.fepblue.org.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please call us at the customer service number on the back of your Service Benefit Plan ID card, or send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"> Write to us within 6 months from the date of our decision; and Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); and Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.</p>
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"> Pay the claim or Write to you and maintain our denial or Ask you or your provider for more information. <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.</p>

The disputed claims process (*continued*)

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street, NW, Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service number on the back of your Service Benefit Plan ID card. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC Web site at <http://www.NAIC.org>.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor’s benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payor (see page 140). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan’s copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan’s payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

• TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

• Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

• Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced, at the Carrier's option, by the Carrier, by any of the Local Plans that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
 - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
 - Uninsured and underinsured motorist coverage
 - Workers' Compensation benefits
 - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

If you are a participant in an approved clinical trial, this health Plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- **Routine care costs** – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. We provide benefits for these types of costs at the benefit levels described in Section 5 (*Benefits*) when the services are covered under the Plan and we determine that they are medically necessary.
- **Extra care costs** – costs of covered services related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers extra care costs related to taking part in an approved clinical trial for a covered stem cell transplant such as additional tests that a patient may need as part of the clinical trial protocol, but not as part of the patient's routine care. For more information about approved clinical trials for covered stem cell transplants, see pages 72-73. Extra care costs related to taking part in any other type of clinical trial are not covered. We encourage you to contact us at the customer service number on the back of your ID card to discuss specific services if you participate in a clinical trial.
- **Research costs** – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

• What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 137.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778), to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you do not have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

(Please refer to page 139 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 23 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When the Original Medicare Plan is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
 - Inpatient hospital per-admission copayments; and
 - Inpatient Member and Non-member hospital coinsurance.
- Under **Basic Option**, we will waive our:
 - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
 - Calendar year deductible;
 - Coinsurance and copayments for inpatient and outpatient services and supplies provided by physicians and other covered health care professionals; and
 - Coinsurance for outpatient facility services.
- Under **Basic Option**, we will waive our:
 - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You can find more information about how our Plan coordinates benefits with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 21 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you – or your covered spouse – are age 65 or over and have Medicare and you . . .	The primary payor for the individual with Medicare is . . .	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and . . .		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member . . .		
1) Have Medicare solely based on end stage renal disease (ESRD) and . . .		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and . . .		
• This Plan was the primary payor before eligibility due to ESRD (for the 30-month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and . . .		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30-month coordination period)		✓
• Medicare based on ESRD (after the 30-month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you . . .		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

* Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

The law requires us to base our payment on an amount – the “equivalent Medicare amount” – set by Medicare’s rules for what Medicare would pay, not on the actual charge.

You are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan.

You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.

The law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on:

- an amount set by Medicare and called the “Medicare approved amount,” or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	Then you are responsible for:	
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments.
	Basic Option:	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount.
	Basic Option:	all charges.
Does not participate with Medicare, and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount.
		Note: In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.
Does not participate with Medicare and is not in our Preferred network	Standard Option:	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	all charges.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

**When you have the
Original Medicare Plan
(Part A, Part B, or both)**

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment (see note below for Basic Option).

Note: Under Basic Option, you must see **Preferred** providers in order to receive benefits. See page 21 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of terms we use in this brochure

Accidental injury	An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. Note: Injuries to the teeth while eating are not considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.
Admission	The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.
Agents	Medicines and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medicines and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT Scans, MRIs, PET Scans, lung scans, and X-rays, as well as those injected into the joint.
Assignment	An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.
Assisted reproductive technology (ART)	Fertility treatments in which both eggs and sperm are manipulated. In general, assisted reproductive technology (ART) procedures involve retrieval of eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Carrier	The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.
Case management	A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2012). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC or NCQA. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.
Clinical trials cost categories	<p>If you are a participant in an approved clinical trial, this health Plan will provide benefits for related care as follows, if it is not provided by the clinical trial:</p> <ul style="list-style-type: none"> • Routine care costs – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes <p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.</p>
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 27.
Concurrent care claims	A claim involving care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. See pages 25 and 26 in Section 3.

Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 27.
Cosmetic surgery	Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial or long term care	<p>Facility-based care that does not require access to the full spectrum of services performed by licensed health care professionals that is available 24 hours-a-day in acute inpatient hospital settings to avoid imminent, serious, medical or psychiatric consequences. By “facility-based,” we mean services provided in a hospital, long term care facility, extended care facility, skilled nursing facility, residential treatment facility, school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long term care can also be provided in the patient’s home, however defined.</p> <p>Custodial or long term care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:</p> <ol style="list-style-type: none"> 1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing; 2. Homemaking, such as preparing meals or special diets; 3. Moving the patient; 4. Acting as companion or sitter; 5. Supervising medication that can usually be self-administered; or 6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems. <p>We do not provide benefits for custodial or long term care, regardless of who recommends the care or where it is provided. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial or long term care.</p>
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 27.
Diagnostic service	An examination or test of an individual with signs, symptoms, or a probability of having a specific disease to determine the presence of that disease; or an examination or test to evaluate the course of treatment for a specific disease.
Durable medical equipment	<p>Equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

**Experimental or
investigational services**

Experimental or investigational shall mean:

- a. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and approval for marketing has not been given at the time it is furnished; or
- b. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- c. Reliable evidence shows that the consensus of opinion among experts regarding the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- d. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

Reliable evidence shall mean only evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations, such as:

- a. Published reports and articles in the authoritative medical and scientific literature;
- b. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- c. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Generic alternative

A generic alternative is an FDA-approved generic drug in the same class or group of drugs as your brand-name drug. The therapeutic effect and safety profile of a generic alternative are similar to your brand-name drug, but it has a different active ingredient.

Generic equivalent

A generic equivalent is a drug whose active ingredients are identical in chemical composition to those of its brand-name counterpart. Inactive ingredients may not be the same. A generic drug is considered “equivalent,” if it has been approved by the FDA as interchangeable with your brand-name drug.

Group health coverage

Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than \$200 per day for hospitalization (including extension of any of these benefits through COBRA).

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. See pages 18-19 for information about how we determine which health care professionals are covered under this Plan.

**Health Risk Assessment
(HRA)**

A questionnaire designed to assess your overall health and identify potential health risks. Service Benefit Plan members have access to the Blue Cross and Blue Shield HRA (called the “Blue Health Assessment”) which is supported by a computerized program that analyzes your health and lifestyle information and provides you with a personal and confidential health action plan that is protected by HIPAA privacy and security provisions. Results from the Blue Health Assessment include practical suggestions for making healthy changes and important health information you may want to discuss with your health care provider. For more information, visit our Web site, www.fepblue.org.

Intensive outpatient care	A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.
Local Plan	A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.
Medical foods	The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.
Medically underserved areas (MUAs)	Each year, OPM determines which states are “medically underserved” using criteria established by Federal regulation. These are states in which 25 percent or more of the residents are located in areas with a shortage of primary medical care providers. For 2014, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, Oklahoma, South Carolina, and Wyoming. Under this Plan, coverage of medical practitioners is not determined by your state’s designation as a Medically Underserved Area (MUA). We cover any licensed medical practitioner for covered services performed within the scope of that license, as required by Section 2706(a) of the Public Health Service Act (PHSA). See pages 18-19 for more information.
Medical necessity	<p>All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:</p> <ul style="list-style-type: none"> a. In accordance with generally accepted standards of medical practice in the United States; and b. Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient’s illness, injury, disease, or its symptoms; and c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient’s illness, injury, or disease, or its symptoms; and d. Not part of or associated with scholastic education or vocational training of the patient; and e. In the case of inpatient care, only provided safely in the acute inpatient hospital setting. <p>For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.</p> <p>The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.</p>
Mental conditions/ substance abuse	Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.
Never Events	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.

Observation services

Hospital outpatient services ordered by the physician to assess whether the member needs to be admitted as an inpatient or can be discharged. If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services – including “**observation services**” – are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your cost-share for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers** – Our allowance (which we may refer to as the “PPA” for “Preferred Provider Allowance”) is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail pharmacies that contract with CVS Caremark) have agreed to accept as payment in full, when we pay primary benefits.
Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the “Preferred rate.” The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 113 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)
- **Participating providers** – Our allowance (which we may refer to as the “PAR” for “Participating Provider Allowance”) is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the “Member rate.” The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers** – We have no agreements with these providers to limit what they can bill you for their services. **This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive.** We determine our allowance as follows:
 - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;

- For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is the average amount for all outpatient surgical claims combined that we pay nationally to contracting and non-contracting facilities. This allowance applies to all of the covered surgical services billed by the hospital and is the same regardless of the type of surgery performed. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient surgical procedure, please call us before your surgery at the customer service number on the back of your ID card to obtain the current allowed amount and assistance in estimating your total out-of-pocket expenses.

Please keep in mind that Non-member facilities may bill you for any difference between the allowance and the billed amount. You may be able to reduce your out-of-pocket expenses by using a Preferred hospital for your outpatient surgical procedure. To locate a Preferred provider, go to www.fepblue.org and select “Provider Directory” to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card;

- For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the billed amount (minus any amounts for noncovered services);
- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount or ASP) or 2) 100% of the Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the “NPA” (for “Non-participating Provider Allowance”);
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greatest of 1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained; or 2) 100% of the Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained; or 3) an allowance based on equivalent Preferred provider services that is calculated in compliance with the Affordable Care Act;
- For prescription drugs furnished by retail pharmacies that do not contract with CVS Caremark, our allowance is the average wholesale price (“AWP”) of a drug on the date it is dispensed, as set forth by Medi-Span[®] in its national drug data file; and
- For services you receive outside of the United States, Puerto Rico, and the U.S. Virgin Islands from providers that do not contract with us or with AXA Assistance, we use our Overseas Fee Schedule to determine our allowance. Our fee schedule is based on a percentage of the amounts we allow for Non-participating providers in the Washington, DC, area.

**Important notice about
Non-participating
providers!**

Note: Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive. Non-participating and Non-member providers are under no obligation to accept our allowance as payment in full. If you use Non-participating and/or Non-member providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances involving covered Non-participating professional care – see page 147). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment. You can reduce your out-of-pocket expenses by using Preferred providers whenever possible. To locate a Preferred provider, go to www.fepblue.org and select “Provider Directory” to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. We encourage you to always use Preferred providers for your care.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than \$5,000 for an episode of care, your responsibility will be limited to \$5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive during an emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services), plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as a radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or pediatric sub-specialist; and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providers in a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 90-93).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see page 31 and pages 121-122.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail pharmacies, between pharmacies and CVS Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, CVS Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Pre-service claims

Those claims (1) that require precertification or prior approval, and (2) where failure to obtain precertification or prior approval results in a reduction of benefits.

Preventive Care, Adult

Adult preventive care includes the following services: preventive office visits and exams [including health screening services to measure height, weight, blood pressure, heart rate, and Body Mass Index (BMI)]; chest X-ray; EKG; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for alcohol/substance abuse; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings and screening for abdominal aortic aneurysms as specifically stated in this brochure; and routine immunizations as licensed by the U.S. Food and Drug Administration (FDA).

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed; or
2. The Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.

For more information, see the benefit descriptions in Section 5 and *Other services* in Section 3, under *You need prior Plan approval for certain services*, on pages 23-24.

Residential treatment centers

Residential treatment centers (RTCs) are live-in facilities (although not licensed as hospitals) that offer treatment for a variety of addiction, behavioral, and emotional problems. These programs may include drug and alcohol treatment, confidence building, military-style discipline, and psychological counseling. Many of the programs are intended to provide a less-restrictive alternative to incarceration or hospitalization, or to offer intervention for troubled individuals. RTC programs are often designed to treat children and adolescents and have been described in a variety of ways, including “therapeutic boarding schools,” “behavioral modification facilities,” “emotional growth academies,” and “boot camps.”

No standardized definitions exist for RTCs or for the programs they administer. RTC programs are not regulated by the Federal government. Although some RTCs may meet state licensing requirements and standards, certain types of residential facilities are exempt from licensing or monitoring by the state. Accreditation of these facilities, their clinicians, and staff members varies significantly from state to state.

Benefits are not available for services performed or billed by RTCs. If you have questions about treatment at an RTC, please contact us at the customer service number listed on the back of your ID card.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care (other than those routine costs associated with a clinical trial as defined on pages 73 and 141).

Screening service

An examination or test of an individual with no signs or symptoms of the specific disease for which the examination or test is being done, to identify the potential for that disease and prevent its occurrence.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Specialty drugs

Pharmaceutical products that are included on the Service Benefit Plan Specialty Drug List that are typically high in cost and have one or more of the following characteristics:

- Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology
- Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects
- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our customer service department using the number on the back of your Service Benefit Plan ID card and tell us the claim is urgent. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We/Our

“Us,” “we,” and “our” refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

“You” and “your” refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250. The maximum annual election for a health care flexible spending account (HCFSAs) or a limited expense health care spending account (LEX HCFSAs) is \$2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSAs) is \$5,000 per household.

- **Health Care FSA (HCFSAs)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician-prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

Note: If you are enrolled in the HCFSAs, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSAs without submitting an FSAFEDS claim. When the Blue Cross and Blue Shield Service Benefit Plan receives a claim for benefits, the Plan forwards information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs – there's no need for a claim form or receipt! Reimbursement is made directly to your bank from your HCFSAs account via Electronic Funds Transfer. You may need to file a paper claim to FSAFEDS in certain situations. Visit www.FSAFEDS.com for more information. FSAFEDS is not part of the Service Benefit Plan.

- **Limited Expense Health Care FSA (LEX HCFSAs)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSAs)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSAs.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSAs or LEX HCFSAs and/or DCFSAs, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.
TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- **Class D (Orthodontic) services with up to a 12-month waiting period. Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web sites at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2014

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 per person (\$700 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; 15%* of our allowance; \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists Non-PPO: 35%* of our allowance	37-38, 41-45
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: \$250 per admission Non-PPO: \$350 per admission, plus 35% of our allowance	78-80
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	81-84
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	90-93
<ul style="list-style-type: none"> Medical emergency 	PPO urgent care: \$40 copayment; PPO and Non-PPO emergency room care: 15%* of our allowance; Regular benefits for physician and hospital care* provided in other than the emergency room/PPO urgent care center Ambulance transport services: \$100 per day for ground ambulance (no deductible); \$150 per day for air or sea ambulance (no deductible)	90, 92-93
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$20 office visit copay; \$250 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; \$350 per inpatient admission, plus 35% of our allowance	94-97
Prescription drugs	Retail Pharmacy Program: <ul style="list-style-type: none"> PPO: 20% of our allowance generic (15% if you have Medicare)/30% of our allowance preferred brand-name/45% of our allowance non-preferred brand-name Non-PPO: 45% of our allowance (AWP) Mail Service Prescription Drug Program: <ul style="list-style-type: none"> \$15 generic (\$10 if you have Medicare)/\$80 preferred brand-name/\$105 non-preferred brand-name per prescription; up to a 90-day supply Specialty Drug Pharmacy Program: <ul style="list-style-type: none"> See inside for details 	98-111

Standard Option Summary – continued on next page

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan
Standard Option – 2014 *(continued)*

Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	67, 112-116
Special features: Health Tools; Blue Health Assessment; MyBlue [®] Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder SM ; Healthy Families; <i>WalkingWorks</i> [®] Wellness Program; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		118-120
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	<ul style="list-style-type: none"> • Self Only: Nothing after \$5,000 (PPO) or \$7,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after \$6,000 (PPO) or \$8,000 (PPO/Non-PPO) per contract per year <p><i>Note:</i> Some costs do not count toward this protection.</p>	31-32

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan

Basic Option – 2014

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 21. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; \$25 per office visit for primary care physicians and other health care professionals; \$35 per office visit for specialists Non-PPO: You pay all charges	37-38, 41-45
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: \$175 per day up to \$875 per admission Non-PPO: You pay all charges	78-80
<ul style="list-style-type: none"> Outpatient 	PPO: \$100 per day per facility Non-PPO: You pay all charges	81-84
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	PPO: \$50 copayment for urgent care; \$125 copayment for emergency room care Non-PPO: \$125 copayment for emergency room care; you pay all charges for care in settings other than the emergency room Ambulance transport services: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	90-93
<ul style="list-style-type: none"> Medical emergency 	Same as for accidental injury	90, 92-93
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$25 office visit copayment; \$175 per day up to \$875 per inpatient admission Non-PPO: You pay all charges	94-97
Prescription drugs	Retail Pharmacy Program: <ul style="list-style-type: none"> PPO: \$10 generic/\$45 preferred brand-name per prescription/50% coinsurance (\$55 minimum) for non-preferred brand-name drugs Non-PPO: You pay all charges Specialty Drug Pharmacy Program: <ul style="list-style-type: none"> See inside for details 	98-111
Dental care	PPO: \$25 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; \$25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	67, 112-113, 117
Special features: Health Tools; Blue Health Assessment; MyBlue [®] Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder SM ; Healthy Families; WalkingWorks [®] Wellness Program; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		118-120
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	<ul style="list-style-type: none"> Self Only: Nothing after \$5,500 (PPO) per contract per year Self and Family: Nothing after \$7,000 (PPO) per contract per year Note: Some costs do not count toward this protection.	31-32

2014 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services), NALC, NPMHU, and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal Category 1 rates apply to career bargaining unit employees covered by the Postal Police contract.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Standard Option Self Only	104	\$196.68	\$87.82	\$426.14	\$190.28	\$65.96	\$79.62
Standard Option Self and Family	105	\$437.62	\$204.98	\$948.18	\$444.12	\$156.36	\$186.75
Basic Option Self Only	111	\$182.90	\$60.96	\$396.27	\$132.09	\$40.24	\$53.04
Basic Option Self and Family	112	\$428.27	\$142.75	\$927.91	\$309.30	\$94.22	\$124.20